VETERAN ACCESS TO VA OUTPATIENT CARE AND RELATED ISSUES

Y 4. V 64/3: 103-22

Veteran Access to VA Outpatient Car...

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JULY 21, 1993

Printed for the use of the Committee on Veterans' Affairs

Serial No. 103-22

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VETERAN ACCESS TO VA OUTPATIENT CARE AND RELATED ISSUES

THURSDAY, JULY 21, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:33 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee), presiding.

Present: Representatives Evans, Gutierrez, Long, Bachus.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and welcome. Today, the Subcommittee on Oversight and Investigations is examining veterans' access to VA-provided outpatient care.

As we all know, each VA facility is unique. No two VA medical centers are entirely alike. VA medical centers differ in location, equipment, services provided, staffing, top management style, employee morale and, of course, patient satisfaction.

While many of these differences are not really surprising, VA facilities would be expected to be more nearly alike in other ways, including veterans' eligibility for outpatient care. VA decisions on which veterans are given access to outpatient care and the types of care these veterans receive should be alike or consistent from VA to VA and especially within the same VA facility.

This issue is critically important because, as we will learn in some detail today, access decisions determine if or when veterans receive care and the types of care they will be given.

Through visits with veterans and their family members and other visits to VA medical facilities this subcommittee has become concerned about possible wide variations in VA outpatient access decisions.

Some months ago, the subcommittee asked GAO to examine this fundamentally important issue. Today, GAO will present what it has learned.

Unfortunately, my suspicions about the inconsistency in veterans access to VA outpatient care have been confirmed. The outpatient care provided by one VA facility may be denied by another. Care provided today may not be provided tomorrow. Even at the same VA center, a veteran may be given treatment for one nonservice-connected condition, but denied care for another.

When the provision of outpatient care is based on discretion, the inescapable result is inequity in veterans access to health care. In-

consistency, in fact, may be the most consistent aspect of the VA outpatient care eligibility decision-making process. Because eligibility and access decisions may be constantly changing, veterans, understandably, can become confused and sometimes bewildered or frustrated about VA outpatient services. In some cases there appears to be no system to the VA health care system, particularly in eligibility criteria interpretation.

Certainly, managing a VA facility is challenging. This challenge becomes even greater and more difficult when resources are less than desired. Differences in judgment and management style also exist. But do these factors excuse inequitable treatment? Or should they?

In addition to examining the variations, or perhaps aberrations, which veterans confront day-in and day-out as they seek access to VA outpatient care, GAO was also asked to review the consequences of VA denial of outpatient care to veterans.

These are the issues we hope to learn more about today, and we appreciate the individuals that will testify before us today.

Our first witness panel is comprised of Dave Baine, Director of Federal Health Care Delivery Systems, Human Resources Division, U.S. General Accounting Office. He is accompanied by Paul Reynolds and Michelle Roman.

Dave, your prepared statement will be included in its entirety in the record and you may proceed when you are ready.

STATEMENT OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, HUMAN RESOURCES DIVISION, GAO, ACCOMPANIED BY PAUL REYNOLDS, GROUP DIRECTOR, HUMAN RESOURCES DIVISION, AND MICHELLE L. ROMAN, ASSISTANT MANAGER, BOSTON REGIONAL OFFICE

Mr. BAINE. Thank you, Mr. Chairman, and good morning. We appreciate the opportunity to be here once again—this time to discuss veterans' access to outpatient care at the 158 VA medical centers.

In recent years, witnesses testifying before both this subcommittee and the Committee on Veterans' Affairs have questioned whether veterans have access to VA care when they need it. In response to these concerns, you asked us to examine three issues: how VA determines eligibility for outpatient care; how VA rations such care; and what happens to veterans who are turned away from outpatient clinics.

As you know, veterans' eligibility for outpatient care, by law, is based primarily on a veteran's medical condition or status during military service. Also, VA may ration care when resources are not sufficient to serve all eligible veterans. Consequently, eligible veterans may be turned away without receiving needed medical care for nonservice-connected conditions.

As we recently reported to you, VA medical centers' interpretation and use of statutory eligibility and rationing criteria vary widely. As a result, veterans with similar medical conditions or economic status are receiving care at some centers but not at others. Unfortunately, Mr. Chairman, we are unable to tell you from a systemwide perspective how many veterans are turned away from VA centers. This is because VA's management systems do not include reliable information on those veterans who leave facilities without

receiving needed care. We can tell you, however, the VA's current eligibility and rationing practices, too often, confuse and frustrate veterans.

While totally consistent application of any eligibility criteria is difficult, if not impossible, to achieve, we believe VA centers should and can become more predictable in their eligibility decisions. Currently, however, because of inadequate VA guidance, medical center physicians are relying primarily on subjective judgments when deciding who is eligible for outpatient care. We therefore have suggested in our report to you, that the Secretary of Veterans Affairs do one of two things. The Secretary should develop and propose to the Congress an alternative eligibility criteria which produces more predictable eligibility decisions or provide better guidance to centers so that physicians may achieve more consistent determinations when interpreting the current criteria.

Consistent with VA's decentralized management philosophy, medical center staffs are making rationing decisions based on locally developed policies. However, it is unclear whether the Congress intends that rationing decisions be made on a local or systemwide basis.

From a veteran's perspective, it seems preferable that VA develop a strategy to deal with resource shortfalls on a more equitable basis systemwide. Therefore we suggest that the Congress consider directing the Secretary to modify VA's system for allocating resources to the medical centers, so that veterans with similar economic status or medical conditions are provided more consistent access to outpatient care.

I would like to take a few minutes now, if you would permit, to discuss in a little more detail what we found regarding the three issues you requested us to look at.

First, on the issue of eligibility, VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. To assess medical centers' implementation of this criterion, we used medical profiles of six veterans developed from actual medical records and presented them to 19 centers for eligibility determinations. At these 19 centers, interpretations of the criterion ranged from permissive to restrictive.

For example, five centers determined that all six veterans would be eligible for care, as compared to three centers that found only two veterans eligible. The other 11 centers used more middle-of-the-road interpretations.

From a veteran's perspective, such varying interpretations mean that their access to VA care will depend greatly on which center they visit. Of the six veterans we profiled, none was consistently determined to be eligible or ineligible for care at all 19 centers. For example, if one veteran had visited all 19 medical centers he would have been determined eligible by ten and ineligible by nine.

Officials both at the headquarters and medical centers' level agreed that the "obviate the need for hospitalization" criterion is an ambiguous and inadequately defined concept. They believe that because the term has no clinical meaning its definition can vary among physicians or even with the same physician. With thousands of VA physicians making such decisions every day, the number of potential interpretations is, to say the least, very large.

Second, on the issue of rationing. The Congress established priorities for VA to use in providing outpatient care when resources are not available to care for all veterans. VA has delegated rationing decisions to its 158 centers; that is, each must make independent choices about when and how to ration care. VA does not systematically monitor medical centers' rationing procedures or policies.

One hundred and eighteen centers reported to us that they rationed outpatient care in fiscal year 1991 for nonservice-connected conditions. Forty reported no rationing. Rationing generally occurred because resources did not always match demand for VA care.

Of the 118 centers, 69 rationed only higher income veterans, 27 rationed to higher and lower income veterans, and 22 rationed to higher and lower income veterans as well as those who also have service-connected disabilities.

The 118 centers which rationed care used differing methods for such rationing. Some rationed care according to economic status, others by medical service, still others by medical condition. The method used can greatly affect who is turned away. For example, higher income veterans frequently receive care at many centers while lower income veterans or those who have service-connected disabilities were turned away at other centers. We think the VA could reduce such inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from the 40 medical centers that had sufficient resources and therefore did not ration care. Such resource shifts could mean, for example, that some higher income veterans at those centers might not be able to obtain care in the future, but it could also mean that some veterans with lower incomes who had not received care at the other centers might receive care in the future.

Finally, as you requested, we examined veterans' efforts to obtain care from alternative sources when VA centers did not provide it. To do this, we selected six centers and 198 veterans judgmentally, because VA's management systems do not maintain reliable information on veterans who did not receive care. This information could be obtained only through discussions with officials of the medical centers and reviews of individual medical and administrative records of individual veterans.

Through discussions with each of the 198 veterans we learned that about 85 percent of them obtained medical care from alternative sources after VA centers had turned them away. Most obtained care from outside the system, but some returned to VA for care either at the same center that turned them away or at another center. Inability to pay was the most often cited reason by veterans as to why they did not obtain care elsewhere.

Some requested medications for chronic conditions such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could have been life-threatening. In other cases, the conditions were potentially less serious.

VA staff face difficult medical and administrative choices each time they consider turning away a veteran needing care. Should

they provide all the diagnostic testing, knowing that the tests are likely to be repeated when the veteran goes elsewhere to get care? Or should they minimize the tests provided, knowing that they will be unable to provide care even if it is needed? VA centers exercise wide latitude in making these decisions when providing care to veterans.

In summary, Mr. Chairman, it is our feeling that veterans are too often being made to feel like they are participating in a health care lottery where their chances of receiving care are heavily dependent on which center they visit, which physician examines them, or which day of the year they need care. As a result, veterans are understandably confused and frustrated about whether they will receive care when they need it.

Physicians, we found, are also uncomfortable with the current system. They continually have to decide whether to deny care to veterans before determining how best to meet veterans' needs. Too often, physicians are required to judge without adequate guidance whether a veteran's condition will, if left untreated, deteriorate and result in hospitalization. This places physicians in a very tough spot—relying on subjective judgments to make difficult eligibility decisions or ignoring statutory requirements in order to serve veterans' needs.

As you know, Mr. Chairman, VA has reviewed our draft reports that are being released today and has generally agreed with our findings and conclusions. In general, VA plans to provide an eligibility reform proposal for consideration by the Congress, and, in fiscal year 1994, to implement a new resource allocation process. VA officials believe that these actions will address the types of service variabilities we found.

That concludes our prepared statement and we will be glad to take your questions.

[The prepared statement of Mr. Baine appears at p. 55.]

Mr. EVANS. Thank you.

Before we go to questions, let me recognize the gentleman from Alabama for any opening statement he may have.

OPENING STATEMENT OF HON. SPENCER BACHUS

Mr. BACHUS. Thank you, Mr. Chairman. I appreciate the opportunity to address this committee this morning on the important issue of accessibility to outpatient health services for veterans.

Fortunately, veterans who utilize the Birmingham VA Medical Center in my district are among those 20 some centers who don't have rationing, and I am obviously proud of that fact. But I am also concerned about those veterans who are not so lucky.

And I am interested, Mr. Baine, in your testimony, particurlary as to whether this rationing is the result of limited physical or personnel resources. We do know that it prevents veterans from receiving medical care that could be effectively administered on an outpatient basis. I think you would agree we have veterans who slip through the cracks and may eventually find themselves in need of more expensive inpatient care.

Mr. Chairman, I hope we come away from this hearing with a clear understanding of the need for eligibility reform within the VA system. Being able to appropriately assess and treat the health

care needs of our veterans is paramount to providing cost-effective and successful treatment.

Thank you.

Mr. EVANS. You are welcome. Thank you.

Dave, during the course of your work have any alternative eligibility criteria which would produce more predictable eligibility been suggested to the GAO staff by the Veterans Administration?

Mr. BAINE. Mr. Chairman, we have seen various drafts of the eligibility reform proposal, but officially, VA has not said which way it is leaning. And I believe, if I am not mistaken, the reform proposal is now not expected to be presented to the Congress until the national health proposal is presented to the Congress sometime this fall.

Mr. EVANS. In your opinion, how would eligibility reform achieve consistent decisions among the thousands of decision makers at the hundreds of VA facilities?

Mr. BAINE. As we understand it, having looked at several alternatives for the reform proposal, VA would expect to, in consultation with the Congress, come up with a continuum of care for a certain segment of the veteran population. The question is, I believe, how deep into the veteran population is the Congress and VA willing to go based on the funds available? The eligibility rules now are such that service-connected veterans must be treated in VA, but it is our understanding that VA intends to propose a continuum of care for a certain segment of veterans, and the debate over the issue is how deep into the veteran population can the Congress and VA afford to go.

Mr. EVANS. On what criteria should eligibility reform proposals be judged?

Mr. BAINE. It is our sense that there are certain basic tenets that I think VA intends to follow and that we would agree with. For example, consistency of access for similarly situated veterans is one of the principal criteria.

The second would be that the eligibility requirements be understandable. That veterans would know that they are eligible or they are ineligible for care.

I think those are the principal criterion. That it would be fair, that it would be equitable, and that it would be understandable.

Mr. EVANS. Can you give us an example of such fair, equitable and understandable criteria?

Mr. BAINE. Well if, for example, it is decided by the Congress that VA should provide a continuum of care for a certain segment of the veteran population that would be an across-the-board eligibility that would be understandable both to those who were eligible and those who are not.

There are other ways, I suppose, to do that, and that is to provide a benefit package for a certain segment of the population and provide a different benefit package for other segments of the population that are announced and understandable. What we have now is individual physicians at every medical center in the country making judgments on the basis of obviate the need criteria that are just plain inconsistent from center to center and even within centers. And so a person might show up at a medical center one day to be told you are eligible for care and we will treat you. On an-

other day it may not happen that way, and it is based on the subjective judgment of individual physicians. That is why the physicians themselves don't like to be in a position to make eligibility determinations.

Mr. EVANS. Let me yield to the gentleman from Alabama at this time and defer my additional questions.

Mr. BACHUS. Mr. Baine, your report, I think, basically identifies 158 facilities and three-fourths of those ration care, approximately?

Mr. BAINE. Approximately. Yes, sir.

Mr. BACHUS. Did you look at individual facilities and find that it was a question of some being efficient, some not in delivery of care, or whether that was the case in some instances or was it just a matter of the facilities not being located where the veterans were? In other words, are our facilities where they should be? Should any of them be closed? Should any of them be expanded?

I know those are hard questions but I think they get right to the core of the reasons why we have these inequities throughout the system?

Mr. BAINE. As you would expect to find if you look across a system of 158 centers, some are more efficient than others. In our travels around the country on this particular assignment and others, you come away with the feeling that some centers could be closed. Or if not closed, at least the missions changed to do what they do best.

The whole issue of rationing becomes one of resource allocation, sir, and the extent to which individual centers are sufficiently funded both in terms of people and facilities and equipment to offer an array of services. The expectation I think is that if a medical center performs a certain medical specialty service, if you will, that that service will be performed consistently over a period of time. That turns out not to be the case because of resource shifts and so forth. And within a medical center, that is what causes a fair amount of frustration among veterans.

Maybe Michelle or Paul could provide a little more detail in terms of when we were going around the country as to what we found at the individual centers. Michelle.

Ms. ROMAN. I think we found many reasons why or causes, but the main cause was, obviously, the supply of resources did not meet the demand. In some cases it was because of specific services.

Mr. BACHUS. Because of what?

Ms. ROMAN. There were certain services where the supply did not meet the demand. In other cases, it was across the board for the whole hospital. I don't know if that helps.

Mr. BACHUS. I think it does. I guess in some cases it is just inefficient delivery of services. Maybe in other cases we might have a small facility that is overwhelmed by a large number of veterans, and then we might have a facility that has greater capacity than the demand.

Ms. ROMAN. I would imagine that it is a combination of factors rather than any one factor in all cases.

Mr. BACHUS. Especially in the case where we have larger facilities than the number of veterans or smaller facilities than the number of veterans. Do we have studies that indicate where these are, and is VA making changes? Are they expanding some facili-

ties? Closing some facilities? Or if they are not, is there political interference?

Mr. BAINE. I think when the Mission Commission did its work and made its recommendations a decision was made not to close any of the facilities. There are folks who disagree with that decision. So rather the emphasis was on changing the missions, if you will. I mean taking certain medical services out of particular centers, concentrate those services in other centers in the region in an attempt to have each center do what it does best.

There is no question, Congressman, that as you go around to the individual centers in this system that some are much, much more efficient than others, and we have done some work for Chairman Evans in terms of trying to come up with some ideas to possibly restructure part of the outpatient, or the ambulatory care portion of VA. There are some centers around that do things very innovatively and others that don't. And so we have done some work and we have given a draft report to VA for its comments, and I hear that in October we are going to have a hearing on that issue. And that deals with sort of your efficiency question.

Mr. BACHUS. I think maybe we have two problems. You are always going to have the efficiency problem, and you will probably always have some facilities that aren't where they need to be or should be, whether larger or smaller. But especially in the case of a facility where the resources are allocated and they don't need to be, or we need to have a bigger facility or a smaller facility. That problem seems like one that, if we could get the politics out of it, we could move forward immediately, especially if the accounting is the same throughout the system.

We probably ought to be able to say here are ten facilities we need to expand and here are ten we need to reduce or close.

Mr. BAINE. The accounting in VA facilities—the cost accounting, if you will, in VA facilities is extremely variable also, and not very good. Basically this comes down to a resource allocation question and an expectation question. It is probably unlikely that the VA is going to be able to be supplied enough money to take care of everybody for everything all the time, and then it becomes a resource allocation question where you have winners, if you will, and losers. The tough questions are going to be who is going to be on either side of that—who are going to be the winners and who are going to be the losers, even under an eligibility reform proposal. They are very, very difficult questions.

Paul.

Mr. REYNOLDS. I think that is the thing that we have seen with VA that maybe is most troubling. They are not doing the kind of analysis or assessment that you are considering. We didn't see where they were looking at the places that were rationing and taking into consideration the veterans turned away, how many, what they were needing, to see if resource shifts would be reasonable, and that is the kind of thing that I think this new resource allocation system could provide. They need to take into account not only who they are serving but who they are not serving, and if the resources are not properly spread around the country, to move them where they are more appropriate.

Mr. BACHUS. Thank you. I think the fact that we have 40 centers where there is no rationing and 22 centers that ration even to service-connected veterans indicates we have either a resource problem or an efficiency problem or both. But I would think that in at least some instances it is simply a matter of a facility that needs to be closed or a facility that needs to be expanded, and we ought to move forward and try to put politics aside.

I almost think about the idea of having some independent commission, sort of like a base——

Mr. BAINE. That is not without its difficulties either.

Mr. BACHUS (continuing). But some sort of a commission, and maybe let some of the veterans' organizations have membership in that. But I don't know who would sit on it.

Okay. Thank you.

Mr. EVANS. For purposes of an opening statement and questions, the chair is pleased to recognize the gentleman from Illinois.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. I would like to thank you again for bringing the issue to our attention. I think it is a very important debate as we think about our national health care reform and, hopefully, to be able to adjust to the new health care environment when we do so.

Outpatient care in some areas is one of the most basic areas of health care and yet one of the most worthwhile. Outpatient care allows us to treat health care problems before they spiral out of control, both medically and financially. Outpatient care allows people to get the attention they need and also carry on with their daily activities that are important to themselves and their families.

I know that the General Accounting Office has put a great deal of study into this problem. I was particularly struck by Mr. Baine's written testimony where he indicated that health care because of the lack of standards in granting or denying outpatient care can become kind of like a lottery. Mr. Chairman, it is one thing to ask people to play a lottery and win a hundred million dollars, as they did in Wisconsin. We know how very few of them win. I probably wouldn't have a problem encouraging someone to spend a dollar, but not very much more than that. But certainly health care, we shouldn't force people to take a chance on whether they are going to get good health care or not. The stakes are just too high.

I think we shouldn't leave it up to a roll of the dice, and we should encourage a situation where luck is not a factor. Luck of what city you live in and what doctor you see in terms of whether you win or lose. I think we should find a way, especially because of the testimony we have received here in this committee and at other hearings where the veterans' community has discussed health care reform and their fear that the Veterans Administration and their hospitals would be absorbed into a national health care system.

And, of course, the members of this committee and other Members of Congress have said, No, we're not going to do that. We are going to make sure that you have those special resources and that the Veterans Administration keeps open the veterans' hospital and that it won't be absorbed. The President has said so. Everyone has said so.

Well, it seems to me that this report begs the question about health care reform and how it is we are going to maintain, and so with that I would just like to ask Mr. Baine and others. Given the fact that we're studying health care reform, there should be a health care reform package that is coming here. The consumers of the VA health care system, as it is currently having difficulty providing outpatient care, one of the great issues is that under a health care proposal that President Clinton is talking, and let's just assume for a minute that everybody would have that health care, we would all have a health care card—veterans and nonveterans alike.

Do you really think that they are ready to compete with the local hospital, that they are ready to compete with other health care facilities if given, and what kinds of things did you see in your study that might not bode well or bode poorly for maintaining a separate health care system, separate and apart from a national one?

Mr. BAINE. Congressman, both in this particular assignment and others that we have done, we have some concerns about VA becoming a competing provider under a national health, reform proposal. There are some things, we believe, VA would have to take into pretty strong account. They are not particularly strong, as you have heard a couple or few weeks ago, I think, in terms of care for female veterans.

There is also the question of whether the veteran would end up having to go to the VA system and his or her family go to another provider because the system is not particularly good with female veterans. They also don't do pediatrics. There are some other issues around that particular question.

So how the VA system would fit as a competing provider in a national health reform I think is pretty much up in the air.

The other aspect that comes to mind is that VA's emphasis has historically been based on the provision of inpatient care and it is only recently that it has gone to an ambulatory care or a full spectrum of service. And the extent to which VA can get out front in terms of the provision of ambulatory care, will be in my view anyway a significant determinant as to how good it is going to be, how well it is going to be able to perform as a competing provider.

Does that answer your question?

Mr. EVANS. Thank you. Dave, some of the veterans who were denied access to VA health care did not obtain health care from non-VA providers. What can you tell us about the medical condition of these veterans and the types of care they needed?

Mr. BAINE. Michelle is probably in a lot better position to do that than I am. I think the overall answer is the conditions of the folks who sought care and were turned away, I think there were 30 out of 198, if my memory serves me. It doesn't always. But the conditions, as I recall, really were all over the place. There were simple conditions. There were potentially life-threatening conditions. And it just ran the whole spectrum, as you would imagine from a randomly selected group of people.

Michelle.

Ms. ROMAN. In some cases they were coming for a diagnosis. They just had symptoms. And because they didn't receive further care, we don't know what the end result was, what the final diag-

nosis would have been. In other cases, they came for a known condition, such as hypertension, and were seeking treatment for that. And, as Dave indicated, it ran the full spectrum.

Mr. EVANS. I understand about half of the veterans who were denied care had no health insurance whatsoever?

Ms. ROMAN. About that.

Mr. EVANS. Some veterans who may have been going to the VA for many years were also turned away as a result of the changes in the resources and given prescriptions for a short period of time. Do we have any statistics about the number of veterans who may have been in that category, veterans who ran out of prescription drugs? Within 90 days, let's say, or so?

Ms. ROMAN. Not right off the top of my head. I don't have that information. Because of their different diagnoses and so on, if it was indicated in the medical records that they had been provided prescriptions, we would know that; otherwise we assume if they did not receive further care that they ran out of the prescriptions. But like I said, right here I don't have the precise number.

Mr. EVANS. How effective is the VA in assisting veterans obtain non-VA health care?

Ms. ROMAN. Well, generally each medical center we went to told us that they will refer them at least to social work service. And then a lot of veterans may choose not to go to social work service. Some do. We found a full range of the help provided at the medical centers we visited.

I know that in some cases we looked at you might even have somebody call over and arrange an appointment, whereas in other cases the veteran may have just been referred to social work service and the veteran may have decided not to go to seek further help.

Mr. EVANS. Is the VA's resource planning and management process more likely to be successful than prior VA efforts to achieve equity of access?

Mr. BAINE. I think I would be pretty circumspect in answering that yes. It is too early to tell, Mr. Chairman, because the VA, as you well know, has gone a couple times around the block with regard to resource allocation methodologies. And while technically, for example, the RAM, which was in effect up until a couple of years ago, or maybe a year ago, technically or conceptually that made a lot of sense. When they got to the implementation of this it was a data-driven thing and people gamed it, and the thing sort of went haywire and they quit it.

So there are many aspects of the new methodology that look promising in terms of being able to allocate resources on a case-mix basis and so forth. The proof of this is how it is going to be, in fact, implemented.

There is probably one other point that we ought to make in terms of that. The new methodology is based, I believe, on the historical activity of medical centers. It does not take into account what the medical centers have not historically provided, for example, the extent to which veterans have turned away. So it remains to be seen, given that fact, as to whether this methodology is going to take care of this kind of a problem in terms of identifying and

being able to sort of account for folks who show up and for one reason or another do not get served.

Mr. EVANS. Thank you. Does the gentleman from Alabama have any other questions? The gentleman from Illinois?

Thank you very much. We appreciate your testimony here today.

Steve Trodden, Dr. Rodney Zeitler, and Dr. David Lee are the members of our next witness panel. Steve is the Inspector General of the Department of Veterans Affairs. Dr. Zeitler is the Associate Chief of Staff for Ambulatory Care at the Iowa City, Iowa, VA Medical Center and Dr. Lee is the Associate Chief of Staff for the Ambulatory Care Center at the Boise, Idaho, VA Medical Center.

STATEMENTS OF STEPHEN A. TRODDEN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ORBAN GREGORY AND MIKE SULLIVAN; RODNEY R. ZEITLER, M.D., ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VA MEDICAL CENTER, IOWA CITY, IOWA; AND DAVID K. LEE, M.D., ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VA MEDICAL CENTER, BOISE, IDAHO

STATEMENT OF STEPHEN A. TRODDEN

Mr. TRODDEN. Good morning, Mr. Chairman. It's a pleasure to be with you again today, and to be with my colleagues from the Veterans Health Administration, to my right. And I would like to introduce to the chair and to the committee—I brought two of my staff to the table with me. To my immediate left is Mr. Orban Gregory, who at the time was the Director for our health care audits and did the audits that are the basis for my statement today, and to his left is Mike Sullivan, who is my Assistant IG for Auditing.

In the interest of the committee's time, Mr. Chairman, since you have my statement, since there is a lot of congruence between that statement and that of both the GAO's prepared statement and the answers that Mr. Baine just provided, I am going to be very terse in these opening remarks. I would very much like to continue the dialogue, particularly that which the gentleman from Alabama introduced. I think he is very much on target. So I will summarize my statement now and then leave time for the others, and then, hopefully, for some questions.

As has already been introduced into the record, Public Law 100–322 introduces the terms "mandatory" and "discretionary"—and actually they use the terms "shall" and "may," which have led to the "discretionary" and "mandatory" terminology that is in use today.

In September of 1988, VHA made a conscious policy decision to apply those terms as expressed in the law and to use them to reduce the number of discretionary outpatient visits so as to achieve a measure of equal access to care. That measure was a percentage that was then achieved by the Southeastern Region, one of seven regions then in existence for the VHA.

We issued a series of reports, three to be exact, on veteran access to and eligibility for outpatient care. Our purpose was to determine the effect that the new outpatient eligibility law had and the extent to which VHA had complied with it.

Our first audit was based on a review of national data provided to us by and found in the VHA systems, and we concluded that the

reported workload reductions did not result in more equal access to outpatient care. There are a couple of reasons for that. One, if you measured access to care on a regional basis, you found a fair amount of equality, if you will. The spread was not all that great among regions—eight to roughly 13 percent.

However, if you looked at it on a hospital-by-hospital basis, you found a much wider divergence of access to care, with one hospital having as low as, roughly, one percent of their outpatient visits being discretionary and another having as many as 52 percent. We also found some differences in the way visits were scored, and we will get into that a little bit later. I think when you start measuring access to care in terms of percentages of visits there is the distinct possibility of penalizing the efficient hospital.

For example, if a veteran shows up at Hospital A in the course of a year and has his medical conditions treated in three visits, and another identical veteran, if there is such a thing, with identical conditions goes to Hospital B and they take care of his needs in five or six visits, then obviously if the pressures are to reduce the number of outpatient visits, Hospital B is in a better posture to do that than Hospital A. So, there are some scorekeeping difficulties, and that is also what our first audit found.

We had two basic recommendations. We said to VHA we thought "visits" was not the right measure to be used in addressing this question, and we also thought that the regions were too broad. We thought they ought to move towards some kind of patient-based work unit measure for measuring equality of access, and we recommended that they narrow regions at least to States. The VHA concurred in our recommendations and actually went us one better by saying that they would measure not just States but they would go down to the local hospital level. In our follow-up process, we have continued to be told that the system will be on the air in fiscal 1994.

Our second audit was an audit of a particular outpatient clinic. It was the outpatient clinic in Columbus, Ohio. We concluded that the reporting system there was not monitoring access based on Public Law 100–322. Whereas nationally the VHA was reporting outpatient workload in excess of 90 percent mandatory, we found that at Columbus only 52 percent was mandatory. As a result of that phenomenon, we concluded that VHA was unable to allocate resources among their various VAMCs equitably, and some nonservice-connected vets were receiving care and others were denied care for roughly the same conditions and for the same reasons that Mr. Baine previously discussed.

As a result of that report, we recommended that VHA determine the workload associated with treating nonservice-connected conditions of vets who were less than 50 percent service-connected—I apologize for the complexity of that sentence, but that is the law—we thought that this needed to be determined. We also thought that VHA needed to get their hands around the workload associated with nonservice-connected vets whose incomes were above the level for mandatory treatment but were being scored as mandatory treatment. Again, VHA reports full implementation of these actions by October 1st of this year.

As a result of those two audits, the Chief Medical Director asked us to do at least one more to make sure we hadn't found something that was an anomaly and something that would give him greater confidence that we were on the right track with this phenomenon. So we jointly picked, instead of a separate, free-standing outpatient clinic as in the case of Columbus, we picked a full-service VA Medical Center in Allen Park, Michigan. There we found very similar results—similar levels of misreporting about patient workload, VHA not in compliance with the definitions and terminology of Public Law 100–322, and similar difficulties in allocating resources accordingly.

And the new factor we found there was that the biggest impediment to full compliance and consistent application of the law was the lack of specific policy guidance with regard to the term "obviate the need for hospitalization."

As a result of that audit, we recommended that regulations be developed to further define the criteria for "obviate the need." With this recommendation, there was disagreement, frankly. The Chief Medical Director wasn't convinced that it was clinically possible to do so, and I have some sympathy with the clinical difficulties that the current law and the current definitions place on our clinical staff.

We took the issue to the Deputy Secretary for resolution. He took the position that VHA should be given time to come forward with a legislative proposal that would change some of these eligibility definitions and requirements. And, of course, subsequent to that decision there was an election and a change in administration and our recommendation is still on hold pending the results of the national health care reform.

VA's eligibility proposals and eligibility reform proposals have been fairly tightly held within the VA as a result of White House direction in an attempt, a legitimate attempt, to ensure that whatever the VA proposes is consistent with what the White House intends to propose to the Congress with regard to national health care reform.

So, Mr. Chairman, I will close—although that is a brief summary of our three audits in this area, I will close by saying that I believe that the gentleman from Alabama is exactly on target. That this issue that we are talking about today is symptomatic of a larger problem, and that larger problem is how VA plans for and allocates its resources. It is very much a resource allocation question.

I would go one step further, though. I would think it is also a question of a lack of performance-based budgeting. I would think it is a lack of reluctance on the part of VHA to define the parameters of equality of reform. By that I mean staffing guidelines, for example.

From the day I took this job until the present, I have been calling for the use of staffing guidelines so as to ensure some rough equality of resources among various VA hospitals. I have heard all of the reasons why that's tough to do and why no one hospital is identical with another one. I understand that. I accept the validity of that. However, I don't think it is a good answer.

I would not call for rigid adherence to any pinpoint set of staffing parameters. I think if we could get very gross equality, very rough

equality hospital to hospital and at least have some basis for departure as to why one hospital would be staffed, for example, with 0.3 nurses per patient—and these are strictly fictitious numbers that I am making up right here—why one hospital would be staffed with 0.3 nurses per patient and another might have a one to one ratio, or a 0.8 or whatever it is, I think there should be a good explanation for that. And in the absence of such standards I think we get inequality.

What I am really driving at here is I think there is not only an inequality in access to care in terms of whether you get in to an outpatient program. I think even if you get in there may be an inequality in how rapidly you are seen; for example, waiting times. And then thirdly, even if you get in either as an inpatient or an outpatient, there may be an inequality in the VA in terms of the richness of the staff resources available to serve you once you get in. So all of those issues, I would submit, are interrelated.

And then lastly, I would think that the earlier question is very, very appropriate; and that is, how are we measuring equality of access to care? The law is set up, the terminologies of "shall" and "may," and that has been subsequently interpreted, as I said, to move to "mandatory" and "discretionary." But nobody has ever said, to my knowledge, neither the Congress nor the administration, that mandatory means that we will size our hospitals and resource our hospitals so as to take care of the mandatory patients, and only if resources are available as a result, in a shortfall of arrivals of mandatory patients, for example, do we take care of the discretionary. That at least is one argument that might be implied from terminology such as mandatory and discretionary.

In the absence of such guidance, the VHA put out, and I think with some merit—it is as good as any other argument—they said, well we will define equal access to care as no more than eight percent of our outpatient visits will be discretionary. It could be 0. It could be eight. It could be 24. I think that is a public policy question that the Congress and the administration really ought to wrestle with it. But it should be defined, how should our hospitals be sized. And then once that definition is given as to what degree of discretionary care is the target, then it would seem to me to follow that when mandatory workload falls below whatever is defined as the acceptable ratio, then resources would flow from a hospital with less than the predicted or prescribed workload and flow towards hospitals with equal or greater mandatory and defined ratios of discretionary care.

I may have confused you, Mr. Chairman. I will try one simple example. If you had an outpatient clinic that was set up to handle a thousand work units, however we define a work unit, and had all the resources—the docs, the nurses, the receptionists, and what not—to take care of a thousand work units; and if we defined an acceptable ratio of eight percent, for example, then you would say in a course of time you would expect that hospital to have 920 mandatory work units and 80 discretionary. If the mandatory work units fell below the 920, you either increase the 80 so as to not have idle or excess capacity and thereby distort the prescribed ratios that we are supposed to have around the country or over time reduce capacity—now this is, obviously, something that couldn't be

done day to day or even week to week. But over time you would have to adjust the capacity of that clinic downward, if eight percent is your prescribed goal, and move the resources to a clinic that maybe isn't able to meet its statutory requirements.

I don't see that kind of resource planning in the VA. I don't see its existence now. I am told that it is coming in RPM–2 or whatever it is called, but a lot of things in VA have always seemed to be right around the corner. But I very much agree with the gentleman from Alabama that these are the central issues surrounding this question.

That concludes my opening remarks, Mr. Chairman.

[The prepared statement of Mr. Trodden appears at p. 61.]

Mr. EVANS. Thank you, Steve.

Dr. Zeitler.

STATEMENT OF RODNEY R. ZEITLER, M.D.

Dr. ZEITLER. Thank you, Mr. Chairman. I am pleased to have the opportunity to address this subcommittee on veterans' access to health care.

To provide the subcommittee a perspective on what has occurred at the VA Medical Center, Iowa City, I will recount events as they relate to this issue.

In 1989, the medical center was faced with a severe budgetary deficit of $2.9 million. Because of inadequate resources and/or resource distribution constraints, we were unable to take care of all our existing patients. As a result, a decision was made to decrease (1) the number of outpatients cared for, (2) the non-urgent Category C admissions, and (3) the census in the community nursing home program, so that workload was in closer alignment with funding available.

At the same time, the Department of Veterans Affairs established an objective of regional equity. This was driven by the need to constrain total workloads to available levels of funding while striving for regional equity of access. Thus, we were allowed to provide only 1.5 percent of our total inpatient workload to discretionary inpatients and 8.3 percent of our total outpatient workload to discretionary outpatients. Each medical center's situation was a little different, which resulted in patients not having equity of access throughout the VA system as a whole.

I will address only the reduction of care to outpatients. The process utilized to reduce the outpatients cared for was as follows:

The medical records of patients with an appointment of greater than six months were reviewed by registered nurses to determine if the condition for which they were being followed was "chronic and stable." "Chronic and stable" was defined as having no change in medication or treatment for a 90-day period. The review process began with the lowest priority veteran, Category C, and continued through Category A Group IV veterans. If there was any question as to whether the condition was chronic and stable, the relevant physician was consulted.

Once patients were identified as being chronic and stable, their names were forwarded to Pharmacy Service. If the patient was receiving medications from the clinic for which they were being discharged, a 30-day supply was forwarded to them in addition to a

notice of what clinics they were being discharged from and what clinics for which they were still eligible. There were some exceptions made for certain patients.

This process affected approximately ten percent of our 15,000 outpatients followed at Iowa City.

This reduction or rationing of care had a significant effect on the morale of the clinical staff. The staff were confused by this approach to budget deficit reduction. They resented having patients who had been most successful in treatment, those with stable medical conditions, being discharged. Success was rewarded with discharge from care.

A large percentage of these patients had no health care provider in the community or could not afford community care. This was in part due to their long-term reliance on the VA for medical care. Patients had allowed their health insurance to lapse or could no longer obtain insurance even if they could afford it. These patients were placed in a very difficult position of having a chronic, although stable, medical condition and limited options for care.

Because of our concern about where these patients would find an alternate source of care, we conducted a study in conjunction with our Health Services Research and Development Service. In June of 1989, a mailed questionnaire was sent to each of the 1968 patients who had been affected thus far. The study found that one-third of the respondents reported that their health status had declined. Twenty-five percent reported that they had not sought follow-up care. And 54 percent were not taking all of their previously prescribed medications. This study, "Shifting the Financial Burden: The VA Ambulatory Care Discharge Policy," was later published in Health Services Management Research.

I understand that resources are limited. I am well aware of our finite clinic space and staffing. I know the costs of medications, diagnostic studies and other treatments. I would welcome an eligibility reform proposal for ambulatory care that would allow us to be more consistent with the amount of resources we are allotted.

In closing, I would remind you that the most vulnerable patients in our system are the low income, or Category A, veteran. If we do not provide their care, who can or will?

Thank you, Mr. Chairman.

[The prepared statement of Dr. Zeitler appears on p. 66.]

Mr. EVANS. Thank you, doctor.

Dr. Lee.

STATEMENT OF DAVID K. LEE, M.D.

Dr. LEE. Thank you, Mr. Chairman. I am similarly very grateful for the opportunity to address the subcommittee on the issue of health care access and eligibility reform for veterans. It is an issue which I also regard as one of great and growing importance, and I would like to summarize my written comments into three basic points.

The first one is to fundamentally agree with the General Accounting Office's report we have just heard, and that is that current regulations governing eligibility for VA health services and access to health care are complex and very unevenly applied. This results in a markedly different access to health care for American

veterans in different parts of the United States. We have several different windows by which we can gauge this. One is the General Accounting Office report that we just heard.

I am the immediate past president of the Association of Ambulatory Care Physician Managers within the VA, called NAVAPAM. In our conversation, we mirror what the GAO report found; that is, the practices range from wide-open acceptance of any veteran presenting to the facility to very strict rationing to those who are absolutely statutorily mandatory and eligible entitled.

Within the Western Region of the Veterans Administration, the planning activities there have conducted two separate surveys. The first survey simply asked the facilities what practices they were employing to ration health care and we got back an incredible array of different practices within each individual facility. The second one tried to make that somewhat more systematic and asked within categories what are you doing for certain restricted sorts of services, such as dermatology, cataract replacement, and joint replacement. The data from that survey similarly reflect wide disparities in services.

For example, if you had a dermatologic problem within the Western Region and presented to one facility, you could be seen within two days. In another, it might take more than a year. We have also, of course, heard from the voice of the patients that this is an unacceptable situation.

Now, previously the historic eligibility derived from centering around the inpatient or hospital-based episode of care. At a time when that was the principal locus of care and where most health care outcomes were going to be influenced by care in that arena, that might have been appropriate. But now, Mr. Gutierrez, as you already have mentioned, ambulatory care has become a broad and increasing arena for health care and one of the most important for preserving and improving health care status, so that ambulatory care access is much more important.

That leads me to my second point, and that is that the inequity of access and the related inability to receive health care services does have significant consequences for veteran patients and for the VA system. I would like to begin with a story that I incorporated into my written remarks.

We recently had a gentleman who is 74 years old move from Montana to Jerome, Idaho, which is about a hundred miles from the Boise VA facility. He had been receiving care regularly at one of the Montana facilities. His health history is such that he has chronic obstructive pulmonary disease. Fifteen years ago he had lung cancer and had to have one lung removed. As a result, he is a pulmonary cripple and has to be on chronic home oxygen therapy.

In addition to that he has carcinoma of the prostate gland, congestive heart failure, and a very slow gastrointestinal bleed from an undefined source. In short, this fellow is sick.

However, all of those problems were stable, so when he presented to our facility he was told of our current policy; that if you are nonservice-connected and stable you currently cannot be incorporated into our ongoing reappointed clinic system. So he went back to Jerome, Idaho, and when he got there he discovered that no one there was willing to accept his Medicare. Idaho has the low-

est physician-to-patient ratio in the entire Nation, and so access to sources of care outside the VA are very, very limited.

In desperation, he appealed to his congressional delegation, and after review we made an exception for him. But many of the 1203 patients we have on our waiting list for access to our primary care clinics have similarly compelling stories, and because of the budgetary constraints we clearly cannot make exceptions for them all.

To try to quantify the consequences to veterans, we have the companion study that we heard from the General Accounting Office indicating that roughly 15 percent of the patients within six months to a year were not able to access care. In reviewing that data, some 40 percent of those veterans apparently had incomes in excess of $20,000, which is quite a bit higher I think than what we have experienced within Boise and in Iowa City.

In addition to the study that you just heard from Dr. Zeitler, one of my colleagues in Seattle, Dr. Finn, did another study showing that 17 months after discharge from the Seattle facility, for veterans who had previously been stable but had to be discharged for budgetary reasons, that 23 percent of those veterans had no health care provider; 41 percent of the patients that had hypertension no longer had controlled blood pressure; and in answer to one of the prior questions, 47 percent of them were not receiving medication on a regular basis. So somewhere between 15 and 25 percent of veterans denied VA health care presumably get access to very little health care at all, and we would presume would have bad health care outcomes, at least as demonstrated by the 41 percent of the patients with blood pressures who went uncontrolled.

As Mr. Gutierrez has indicated, that means that we do the inefficient thing of treating the shock or the myocardial infarction that results from uncontrolled blood pressure instead of treating the blood pressure and doing good preventive health services on a regular basis.

In addition, the consequences to the VA system are profound. Turning veterans away when you have defined a health care need has a corrosive effect on health care providers. It is certainly inimical to me as a physician to diagnose someone as having a defined problem and then tell him I cannot treat him, and that is summed across the board. I think this was one of the most consistent feelings and impressions of those of who us who provide care within the VA system.

In addition, we now have a national mandate and increasing concern about the levels of primary care. Many veterans' hospitals are teaching hospitals, and certainly they provide very ineffective and inefficient arenas for primary care education, if we are on a somewhat ad hoc and inconsistent basis disenfranchising patients in an irregular fashion.

My third point, then, is that solutions, I think, are to be found—this has already been intimated—in resource management, resource distribution, perhaps more resources, and in eligibility reform. Certainly we at Boise view ourselves as one of the have-nots of the system and we would welcome more resources so that we could incorporate more of those 1203 veterans into our ongoing programs.

Thank you very much.

[The prepared statement of Dr. Lee appears at p. 68.]

Mr. EVANS. Thank you, doctor.

Both of you have pointed out the enforcement of these regulations fall upon a staff, not only of doctors, but of nurses, of technicians, of other people in the hospital system that really are front line people in carrying out the enforcement of this, and I understand how depressing that can be for people who do want to provide services, so we appreciate your work.

The American Legion has proposed simplifying eligibility by establishing two classifications of veterans: service-connected and nonservice-connected. Service-connected veterans would be entitled to receive the full range of health care services they need from the VA. Nonservice-connected veterans would be eligible, but not entitled to VA health care.

The VFW has adopted a resolution which provides entitlement and eligibility to the full continuum of VA health care for all service-connected veterans rated from 0 to 100 percent, all veterans in receipt of a VA pension, and all nonservice-connected veterans already eligible for access to VA because of their lower incomes.

I want to ask the members of this panel how they feel about these two proposals and how they would simplify eligibility for VA outpatient care.

Mr. TRODDEN. I will take a crack at that first, Mr. Chairman. I would have to think about the two—frankly, I haven't studied the two alternatives in detail, and I would have to really think about it and hold them up side by side to understand completely the differences between the two of them.

But fundamentally, they don't sound that much different than what I think I have been hearing coming from the Secretary in terms of there would be a defined segment of the veteran population that would be entitled to a full continuum of care. And the way he generally says it, the others would be eligible to come into the VA system, assuming they would be allowed to bring with them whatever—their checkbook, their credit card, their national health care reform eligibility or what not.

I think that that does have some benefits to it. It does have simplicity to it. It would allow clinicians to provide the full range of medical care that, in their opinion, the veteran was entitled to. And it would also have the advantage of addressing this capacity question. The way we have it now, as I said earlier, when you have mandatory versus optional or discretionary, that seems to suggest to me that you would capacitize your system for the mandatories, or at least the mandatories plus some percentage of discretionaries. Under those reform proposals you would capacitize, I would think, your system based on plain demand—a combination of the mandatories and whatever other veterans were showing up at your hospital and asking to use your system. Your wouldn't have to guesstimate. You would run it pretty much like a business, and it would be based on expressed demand that would show up.

I think one of the public policy debates that the Congress would have to wrestle with would be how deep, as Mr. Baine said, into that veterans population do you go and provide the full continuum of care and what is the price tag associated with that, and can the Nation afford it in the collective judgment of all of us.

Mr. EVANS. Dr. Lee.

Dr. LEE. I haven't had an opportunity, Mr. Chairman, to previously study those proposals. The American Legion proposal sounds like it would be very similar to the present system, except eliminating a number of subcategories, which get to be very complex. The one from the Veterans of Foreign Wars sounds like it would pretty much enfranchise what we are doing at the present time at Boise, taking care of all service-connected and those who are below the pension level. That would leave, however, a significant number of still indigent but above the pension level veterans for whom access to health care would be exceedingly difficult in the present environment, and unless broader health care reform provided them some access to health care, I think the policy question would be what are we going to do with those veterans?

Dr. ZEITLER. I would have similar concerns to Dr. Lee regarding those veterans that do not have access to care in the community. I think it gets back to the question of resources and our ability to provide care. I believe if we rely on a system where there is some space, our space is quickly filled up and someone is going to be a loser there, and how do you decide who is the loser and who is the winner is very difficult.

Mr. EVANS. Doctors, let me ask you what you would recommend if you could make recommendations about how we could structure eligibility criteria?

Dr. LEE. Mr. Chairman, I would tend to agree with the General Accounting Office that we would favor something that was simple and objective, and I think we would both be advocates for making it as inclusive as it possibly could be. We would really enjoy serving as much of the veteran population as we possibly could.

The present system, which has been characterized as a lottery, is very difficult and it is very unfair to both veterans and providers.

Dr. ZEITLER. And I do believe there is in our system areas where we can be more efficient, and I think there are hospitals that have excess capacity and there are others that are overcapacity. And if there is some way that we can equalize that, I think that would be the solution we would like to see.

Mr. EVANS. As you know, we are still waiting to receive word from the White House concerning its plan for national health care reform. Even if we get a good package, it is conceivable that it may not pass or may not go into effect for years to come.

Should VA eligibility reform be dependent upon the national health care reform legislation or should the VA move ahead now as quickly as possible to reform the eligibility criteria separate from the health care considerations that we will have with the president's reform package?

Dr. ZEITLER. I guess I would like to see the VA move on with their system because it is not clear to me when we will have the other system in place, and I don't feel that we can wait.

Dr. LEE. I would concur with Dr. Zeitler, Mr. Chairman. I think that the present system is badly broken and does urgently ask and require some fixing at the present time, certainly around the areas of resource distribution and at least making the system a whole lot more consistent than it presently is.

Mr. EVANS. The gentleman from Alabama.

Mr. BACHUS. Thank you. I have basically two questions. The first one I am going to direct to the doctors, sort of in reverse order, and then I'll ask the Inspector General a question.

I want to ask you as doctors, not as VA representatives. In the context of the hypocritic oath, or is it Hippocratic—how do you pronounce it?

Dr. LEE. Hippocratic.

Mr. TRODDEN. They would prefer the "a" in there.

(Laughter.)

Mr. BACHUS. You have taken that oath that you are supposed to treat sick people. And it doesn't surprise me that you say, "We would like to include more people," because that is really what your oath tells you you ought to be doing. And then these regulations make you sort of gatekeepers and you make determinations based on whether the veterans' condition is service-connected, and what their income is.

What about how sick they are? Or how easily you can cure the condition? What do the regulations say about that? Let's just say you have a nonservice-connected veteran who has a fairly good income, but you can cure him by prescribing one $2 pill. On the other hand, you have a service-connected veteran who has no income and has a condition that you could treat for three years at a million dollars' worth of expense and not really affect his condition. Now, according to the regulations, I guess you treat the second individual; is that right?

I know I am throwing a lot at you. But you know, we are talking about sickness, we are talking about ability to cure.

Dr. ZEITLER. Well, we treat patients in the context of the regulations that are placed in front of us, but we certainly make decisions based on their medical condition. And if it is a condition that I feel is something that we can treat, we certainly do that. And we, if necessary, find ways that we can treat these individuals.

The medical decision is very important, and we do not want to discharge patients from our care who are not stable or not adequately treated, and that is very important.

Mr. BACHUS. Do those desires—Dr. Lee, I will let you respond before I ask the question.

Dr. LEE. I would essentially agree with Dr. Zeitler. I think how sick the patient is is really the central issue around the obviate. Because when they reach a certain threshold of illness where we seriously think that deterioration of their health status is imminent, there is better consistency around the system, and I think most facilities would incorporate those patients either into the hospital if they are sufficiently ill or into their outpatient programs.

But where you draw the line becomes, again, highly variable from system to system. I have had the privilege of working at two different VA facilities and I must admit that I even had to apply situational judgments because my own interpretation of obviate in the context of one facility was different from what it is in the context of the other facility, so even within facility to facility it is different.

But yes, the patient's medical situation clearly does matter a great deal in these determinations. And those are also complex. It does add another degree of variability.

Mr. BACHUS. Do the regulations allow you the flexibility you think you need in that regard? You said, Dr. Zeitler, that you find a way.

Dr. ZEITLER. Right. Well, I think that does get to the issue of access to care, and it points out that does depend to some degree who you see and where you are seen and the ability to make the system work. I think there is a difference in our facilities and how we can do that, and it may vary within facility quite a bit also.

Mr. BACHUS. I am just saying by categorizing who we are going to treat first really sounds pretty neat, but it is not really an answer to treating a lot of sick patients.

Let me just ask you this. I asked before, but I want to just ask you again. Do regulations interfere with your ability to treat sick patients? Or do the eligibility requirements? Are there some changes we need to make?

Dr. LEE. I think the necessity for rationing clearly interferes with our ability to take care of sick patients beneath a certain threshold, wherever that threshold is drawn within the individual facility. If the patient is sufficiently ill, however, I as a physician choose to define that, then there is infinite flexibility. And, as Dr. Zeitler has implied, I can find a way.

But we do have to draw that line someplace, and when the patients fall beneath that line then clearly it interferes with our ability to take care of patients. Like the one I cited, the 74-year-old with only one lung on chronic oxygen, who clearly is going to need ongoing health care. But given that he was stable at the moment he presented that time, I am going to have to wait for him to get unstable before I can treat him.

Mr. BACHUS. You know, I have heard the statement made in the national health debate on care that is going on that Americans won't accept rationing. Obviously they are in the VA system and have been for years.

Dr. ZEITLER. Rationing can come in various ways. Rationing can be not allowing someone to receive care. But rationing can also mean that you have an appointment in six months when you should have an appointment in two months, but there is no way of getting someone back. So rationing can be at all levels.

Mr. BACHUS. I have another question, if I may. This question goes back to what we started talking about, Inspector General—of what the doctors have recognized as a need to reallocate resources on occasion.

What present ability does the VA have to do that? Are there any internal or external hindrances to the VA being able to do that now?

Mr. TRODDEN. I am going to have to hedge, Mr. Bachus, a little bit on my answer because there are some things I don't know, quite candidly. On the internal side I don't have as good a knowledge as I would like to have about the internal VHA budgeting process. We do have an audit ongoing in that area, and I hope that perhaps the next time I am in front of this committee I will be able to answer that a little bit better.

But it would seem to me that there would be an internal ability to reallocate resources. I think it is, to my way of thinking, it is very clear that it has to be predicated on good standards, good measures, good staffing guidelines—the things I have mentioned previously. I am told that this new system coming in fiscal 1994 will have some of those features. I hate to be a skeptic, but I will believe it when I see it.

With regard to external factors, to be very candid, I think there are clear political considerations when it comes to reallocating resources and deciding whether or not a hospital closes, whether or not a hospital is down-sized or down-scoped in its mission, and those are very, very difficult matters. It is clearly—I think you are right on track that this is an issue that very much needs a clean slate approach and very much needs a national and systemic approach, and we have grown the way we have. And I think it would be counterproductive to get into fault-finding as to who screwed up or who didn't do what. I think, in the vernacular, we're at where we're at and it is—I would subscribe to what these doctors have said—it is broken and it needs fixing, and I think it needs fixing in sort of a top-down way. What are we trying to do? Who are we trying to take care of? How do we measure access to care? What is equality and what is inequality? And then how do you move the resources around to ensure that definition of equality. I think it is just about that fundamental.

Mr. BACHUS. I mentioned earlier a base closure approach. Because any good Congressman, if he is effective, is going to fight for expansion of a facility even if it is half full. He is going to do what politically he is called on to do. He is doing his job. He is sort of like an attorney advocating for his client.

Mr. TRODDEN. Sure.

Mr. BACHUS. You can't expect a Congressman to say close a facility in my district.

What type of an arrangement do you think we could make? Do you think an independent commission would work?

Mr. TRODDEN. I think that might ultimately be in order, yes. But it seems to me that these definitional matters would come first. You know, the public policy would need to be set, the standards would need to be set in terms of how we are going to measure compliance with that public policy. And then when that is done, then you are going to have some answers that are going to show that this particular hospital is not meeting its defined public policy mandate and this other hospital hasn't even got the resources to get up there, you know. So that is going to force the questions of who gets adjusted, who gets resources transferred, and at that stage I would think that it very much might take something similar to the Base Closure Commission to get out of the parochialism and to get into the national kind of concept that I think you are talking about.

Mr. BACHUS. Is it realistic to think that the President—let's say we get our scoring in order, we get the standards set, we make these determinations—could just call Jesse Brown and say do it?

Mr. TRODDEN. I think it is clearly possible he could call Jesse Brown and say just do it. Now what happens after that I think is

a little more problematic. I am not sure what the outcome of that would be.

Mr. BACHUS. All right. Thank you. I am not either.

Mr. EVANS. The gentleman from Illinois.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

I just think that, in terms of continuing the discussion, we do need to have a discussion in terms of this problem in terms of national health care, and we talked about it. Because I just cannot see if a national health care program that even works halfway is not going to have an effect on VA hospitals. These veterans are not going to go to these facilities, and then you are going to encounter—I mean that is going to be good for them. Maybe they will get better health care elsewhere.

I don't believe, and maybe we should ask the veterans' organizations, that veterans go to veteran hospitals because they feel a certain kinship to going to these veteran hospitals because they were a veteran before. I think they go there because they receive care there, receive care there that they might not receive elsewhere, and because it is a right that they have. It is something they have acquired by virtue of being a veteran of the United States. So it is a right that they have acquired to that kind of a service.

I know that is why my father goes to the Veterans Administration and to the hospitals there. I assure you that if I could get my father on my Blue Cross-Blue Shield Plan I don't think he would be in the long lines in Chicago at the veterans' facilities. I think he would go see the doctor at the local hospital and go and get health care there. I know he doesn't go there because he feels that it is some kind of patriotic mission, that because he served in the Armed Forces he has got to go to a veterans' hospital to get health care.

So, if that is true, I just think that all of the veterans' organizations should be very aware and cognizant that if we are to maintain separate facilities for veterans that care about the issues of health care for veterans that we are going to have to do something about the current system. And it would seem to me wise that at the current moment to expand the services and to improve the system, because anything else that we bring on board nationally it seems to me is going to be better than what is going on. Not for all veterans, but for those veterans who are being denied health care.

So, with that I would just like to ask a couple of questions, and just say it seems to me that we are going to have to—you know, we can talk a lot about what we want to do in terms of health care. But how is it that we got here? Somebody made some decisions about who was going to get health care and who wasn't going to get health care, and then they told the doctors and the people who work at the veterans' hospitals this is what you are going to do. Someone made those decisions. And those decisions didn't get made last year or the year before. They got made over a lot of years. And it seems to me that some of those decisions got made as we were sending veterans to Desert Storm, and people knew what we were doing. And while we were very patriotic in sending people over there and getting our Armed Forces, it seems that we weren't con-

sistent with our policies here in terms of providing health care for those people when they returned from action and from war.

So it didn't just happen overnight. We know we spent $30 billion on Star Wars. We could have put the $30 billion into the Veterans Administration over the last ten years and I think we would be having—I think statistically there would have been a lot more veterans served.

So, I think, you know, we can talk about the Veterans Administration, we can talk about the policies, but we cannot talk about them as though—you know, someone wrote them. Someone made these decisions and somewhere along the way we made budgetary decisions that probably propelled these very regulations to come about. So we are going to have to look at this country in terms of the priorities we had because, you know, I sit on the Banking Committee. I am going to go over there, and then we are going to go discuss another $30 billion for the S&L bailout. I mean there was a decision. Someone decided to deregulate the banks in this country during the last ten years, and we know what that brought us, $200 billion worth of misery across America.

So there is a lot of things that I think we need to talk about. And I know that the people on this committee, the people in this room are concerned, and so I think we need to take the word back out.

Let me just go real quickly, Dr. Zeitler. You said in your statement that at your facility patients who are chronic or stable and eventually denied outpatient care. And if they are chronic, that would mean that they demand constant care, but they are denied care. And also, if a patient is stable, their stability is caused by constant care, care that you can get as an outpatient. Could you tell me what you feel has caused this policy to come about that would cause you to deny these people health care?

Dr. ZEITLER. As I understand it, we are following the mandate. Congress told us this is who we can provide care for and the VA has made some determinations based upon that, and then that it has filtered down to our level. So I believe we are doing what we have been mandated to do.

I do want to comment about the satisfaction with our care. From our studies of those patients who were discharged, 94 percent were satisfied with the care they had received from the VA and only 60 percent were satisfied from the care they had received in their community. So I think your father is not alone in his attachment to our system. So I do think we are doing some things right. But we would like to do more things right.

Mr. GUTIERREZ. I understand. The reason I asked the question is not because I don't quite have the answer, doctor. It is just that I want it on the record because there are going to be occasions in which this country is going to call upon its men and women to serve once again, and I am going to make sure that I have that answer in the testimony here today, so that when people ask—and people should know. It is just like anything else and any other agreement which you enter into. You should know just what your country is ready to do for you after you have served your country. Because the flags and the bands, you know, seem to be there, and then they just don't seem to be there later on when people need the health care.

You know, in America, if you would go out there, people all assume all those veterans coming back have health care. They just assume that. And many of the veterans just assume that the VA is going to be there and isn't going to change the rules along the way.

Mr. TRODDEN. Mr. Gutierrez, if I could jump in on that I think I could take this, maybe, one step further. I agree with the doctor's answer. He is trying to comply with the law. And just for the record, to make sure that it is understood, when he uses the terms "chronic" and "stable" that is sort of the antithesis of "obviate the need." In other words, he's got a problem—if he concludes that the patient is chronic and stable, he has got a problem concluding that he needs to admit him in order to obviate the need.

The second point I would make would be with regard to my clean slate approach. It looks to me like the "obviate the need" phraseology stems a long way back to the time when medical care—you talked about veterans returning from Desert Storm or what not getting medical care—well, this term goes all the way back to a time when medical care really meant inpatient care. I mean that was the mind-set. It goes a long way back, and then we are talking about admitting the patient into the hospital. So we evolved as medicine moved more and more to an outpatient basis as VA moved more and more to an outpatient basis, and somebody said, well, who gets into our outpatient clinics?

The framework, the mind-set was, well, we will start with those who get into our hospitals, get in as an inpatient, and then it was just extended; or we will treat them on an outpatient basis as long as it obviates the need to admit them as an inpatient. So there is a certain logic to it, but I think the logic has long since been passed over by the march of modern medicine that would now say you deliver care both in outpatient clinics and in hospitals as inpatients. And maybe even preferably on an outpatient basis—one gets earlier and better care on many occasions as an outpatient than as an inpatient.

Mr. GUTIERREZ. Thank you. Mr. Chairman, I would like to just say to Dr. Lee that I found part of the written testimony the most interesting. You know, when you have to tell people that you are not going to provide them health care, and you talked about the VA as teaching facilities, and all of the young doctors then who come to get trained at VA facilities. And you worried about the new physicians would lack the training in many areas because patients who suffer similar ailments at a given facility would be continually turned away, so that young doctor would never get trained in terms of being there.

I share your concern in that regard, and I certainly—when I go to a hospital I hope the doctor has been trained, if he was trained at a VA hospital, in what I am ill in at that particular moment. And across America, I know we all would want our doctors to have the best training possible and the fullest scope. One would think at a facility—God! you would want a doctor from a VA facility that has seen everybody and seen all kind of—and really had. But if he has to turn a lot of people away maybe he isn't learning everything.

I am also worried that young doctors would become accustomed to the idea that turning people away from outpatient care who des-

perately need it, and I am worried that we are setting a very dangerous and life-threatening precedent for a whole group of doctors who will serve within and outside the VA system. We are teaching them that it is okay to send one outside the door when they still need care.

Do you think this is a legitimate cause of alarm that I have in terms of doctors that train in the VA facilities?

Dr. LEE. Well, absolutely. And thank you very much for picking up on that part of my comments.

Part of the primary care training that we are embarking on, and I think we are really at a very young stage in effective primary care training, is in enabling young doctors to establish effective ongoing relationships with patients and then to see the consequences and the natural history of the disease as they manage it. Those are two of the critical aspects of delivering quality medical care. And when we are in a situation where we are periodically disenfranchising patients from what should be the best, high quality care, we are clearly not modeling what we would like the young doctors of the future to be able to learn. So I very much agree with your comments.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Mr. EVANS. Thank you. It is a distinct pleasure for me to recognize Congresswoman Jill Long, who is rejoining our subcommittee. She has made important contributions to the work of this subcommittee in the past, and, Jill, we look forward to your renewed participation.

Ms. LONG. Thank you, Mr. Chairman. It is really good to be back. Thank you.

I have a couple of questions for Drs. Lee and Zeitler. Today in the testimony, not just your testimony but testimony that we are going to hear later, there are references made to "full continuum of care," and I would like for you to, if you could for the record, talk about what you would mean by a full continuum of care.

Dr. LEE. I will start with that. I would define a full continuum really as being any health care that is defined to be beneficial across the entire spectrum of care, ranging from, I would say, the initial access to care, preventive health care, and primary care for those who are comparatively well, all the way to the most high technology services and some of our most expensive tertiary, or even quaternary, interventions, including such things as organ transplantation, which would be at that high end. So it would range the entire spectrum of state-of-the-art medical care.

Dr. ZEITLER. I agree. I also would emphasize the importance of a primary care provider in that sort of system to guide the patient through as they need the more specialized care to make sure that is provided and there is an advocate for this patient in the system.

Ms. LONG. I would like to ask, in your opinions, do you think it is possible to provide that in a Department of Veterans Affairs system without breaking the bank? I mean can it be afforded, provided within the system?

Dr. LEE. I think it would be very difficult to provide a full continuum of care for all veterans without significantly enhanced resources. My own view is that perhaps we emphasize a little bit too much the high technology interventional end and too little the pri-

mary care base, and over time I think if we rebuilt the primary care base we probably could do a better and more cost-effective job.

One of my colleagues, Dr. John Williamson from Salt Lake City, has looked internationally at various health care systems, indicating that a mix of 50 percent primary care to 50 percent specialty care is about right, and this country has slipped to probably about a 30–70 ratio and outcoming graduates are now at about a 20 to 80 percent ratio. That is mirrored to some degree in the Department of Veterans Affairs, although the numbers are very hard to get at.

But yes, I think it would require significantly enhanced resources if we were to care for very many veterans and offer them a completely full continuum of care.

Dr. ZEITLER. It is generally more costly for a specialist to provide care, and in some cases our specialists are providing primary care because we do not have the primary care providers to do it. So I think we would need to focus our system a bit differently to provide the continuity, but I am not sure it would necessarily require that it be very much more expensive if we have the right focus in terms of primary care.

Ms. LONG. It is interesting to hear you—both of you have made reference to the importance of primary care and how it is cost-effective and also just an effective means of treating patients—because I hear the same thing regardless of the health care or medical community that I am talking to. I have meetings in all of my hospitals back in the district, and I continually hear the same thing. That one of the ways to provide good care to patients and to provide a full continuum of services is to focus a little more on primary care and try to attract more physicians and health care professionals into that area of care.

I have a question for Mr. Trodden as well. In your statement you made reference to performance-based budgeting and reporting. And I come out of business, was a college professor of business administration, and I am not familiar with that term. If you could give us some examples of what you mean by performance-based budgeting and reporting.

Mr. TRODDEN. I think fundamentally what I am driving at there, Ms. Long, would be the difference between some expected level of performance or cost per unit of measure versus what was actually achieved. And that gets us back to defining what it is we are trying to do—defining some norms of resources that ought to be needed to produce a unit of work or produce treatment of a veteran, and then measure what our actual costs and our actual experiences are relative to that norm. Thus, we will have a way of recognizing in our budgeting process when we are dealing with efficiency and when we are dealing with inefficiency.

One last thing I will say, and hopefully it will make this clear. About a year ago I took a briefing on the formative stages of the RPM system—this new resource allocation system that VHA is working on, and this was data coming out of their Boston Development Center—and the hospital director showed me that for a number of hospitals they had a measure of cost per unit of workload. And he said, here are the outliers—meaning here are the hospitals that in this array of data were the efficient hospitals; he called

them low outliers. And here are high outliers. And he says, we are going to use this to allocate our resources.

My response was all well and good, but how do you know that the low outlier, i.e., the low cost per unit of measure, is in fact low because he is efficient or is he low because he is underresourced. And if you had a very resource-poor hospital, you might get a low cost per unit of measure, but maybe he is very undermodernized, maybe he hasn't got the right equipment, or maybe he doesn't have the right numbers of staff. And that is why I keep saying that standards have to go into this equation. You have to know that first before you start rewarding him for being efficient. It may be that he is just underresourced.

So when I talk about performance-based measures I am trying to tie performance in terms of cost management to standards of——

Ms. LONG. Quality.

Mr. TRODDEN. Of quality, right. Yes, ma'am.

Ms. LONG. I do understand now. It is part of strategic and tactical planning in business, so I do understand that.

Could you tell me, and you touched on this just briefly in your first response, what specific actions have you recommended that the Department of Veterans Affairs take to achieve performance-based budgeting and reporting?

This is not an easy—I think I see the parallel between what you are trying to do and what is done in the business community, and it is not an easy thing to accomplish.

Mr. TRODDEN. To be quite candid with you, IGs have two ways of expressing ourselves. We have formal reports where we lay it on the table and we say this is our position and I recommend thus, and so, and the other thing. We also have informal means. Most of the comments that I have made on this issue have been informal recommendations—one-on-one conversations with the Chief Medical Director, for example.

There is also a formal set of recommendations that Mike Sullivan can talk to, that prior to my arrival, he had issued in a formal audit report dealing with staffing guidelines.

Mike, you want to pick up on that?

Mr. SULLIVAN. Yes. Before Mr. Trodden arrived, we issued a report dealing with VHA's nurse staffing guidelines, and in that report we recommended that the Department revise its guidelines in order to determine the number of nurses they needed at each medical center and the types of nurses.

They have rejected that recommendation. It has been an unresolved recommendation for three or four years while they have been trying to come up with a system to revise those guidelines. In the interim we have now decided to look at the physician staffing side of the house, and we have an ongoing audit to try to make that determination. We should report on that next year.

Mr. TRODDEN. The informal response as to why the recommendation was opposed, Ms. Long, was, well, if I develop these guidelines, these standards, that is just going to give my critics like you—meaning me—something to hit me over the head with. And I said, "That's ridiculous." I would never intend to hit somebody over the head for a departure from a standard. There may be very good rea-

sons why a given hospital would have to depart from a standard. But I think there should be very good reasons, you know, and absent that we are all free-floating. And we have wide variances in resource richness and we have wide variances in access to our care.

Ms. LONG. Thank you very much. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Mr. GUTIERREZ. Mr. Chairman, I need to apologize because I need to go to a Banking meeting that started at 10 o'clock. So I apologize to the members. I will be going over there for a while.

Mr. EVANS. I appreciate your attendance.

Mr. GUTIERREZ. Thank you very much.

Mr. EVANS. Doctors, let me ask you a series of questions. Within your respective VA medical centers is ambulatory care treated on par with other medical center services when it comes to resource allocations? Have the resources allocated for VA ambulatory care kept pace with the increased amount of ambulatory care being provided?

Dr. LEE. If I could handle that one first, Mr. Chairman. Yes, absolutely. In my facility ambulatory care is treated on a full par, and, in fact, we are a very ambulatory care/primary care oriented facility. Recently we have innovated three interdisciplinary teams which have been able to demonstrably show improved patient and provider satisfaction. So ambulatory care is on a full par. However, the resources that we have received have certainly not kept pace.

I arrived in Boise in 1984 at a time that we had about 50,000 outpatient visits a year, staff outpatient visits. Since that point in time we have escalated to where we are nearing 90,000 staff outpatient visits a year, and we could clearly do more. We have a waiting list, as I have mentioned, of about 1200 patients, each of whom would probably generate about five to seven visits themselves if we only had the resources to take care of them.

So no, we have not been able to have resources keep pace.

Dr. ZEITLER. Yes. I believe that my director and chief of staff are very supportive of ambulatory care, and we have also seen a movement of resources. I think that I would like to see more resources moved into our area, but that is always the case. So I think they are quite supportive and really understand the importance of ambulatory care.

Mr. EVANS. What actions would reorient the VA to greater reliance on ambulatory care, in your opinion?

Dr. LEE. Within the Western Region I think we have already tried to establish that as at least a regional mandate, and I suspect that you could reorient the entire system if there was a consistent approach from the top saying that ambulatory care had to be an important part of our product mix. Recognition for that is growing, and certainly if the VA is to be part of managed competition it is going to be absolutely essential that we do so.

Dr. ZEITLER. I guess I wouldn't have anything extra to add to that.

Mr. EVANS. Mr. Trodden.

Mr. TRODDEN. Mr. Chairman, at the expense of being flippant, I would have to be very direct with you here and say change the law. I want to make sure the committee is constantly aware that the law makes it tougher for a veteran to get into outpatient care

than it does to get into inpatient. That is set up in Public Law 100–322 and that is a bias against outpatient treatment—fundamentally, statutorily prescribed. So if we wanted to reverse that, I would suggest that as the first place to look.

Mr. EVANS. Steve, in order for resources to be allocated equitably within the VA, accurate information on veterans being treated by the facilities is needed. Do you believe the VA is making progress in improving the accuracy of reported facility workloads?

Mr. TRODDEN. In our follow-up mechanisms, Mr. Chairman, they have continuously advised us that they are and that, as of October 1st of this year, better scorekeeping that would eliminate the problems that we have found will be available. Again, until I see it I have to reserve judgment. But they have advised us they are moving rapidly in that direction.

Mr. EVANS. That is an issue, of course, that we will be interested in.

Mr. TRODDEN. Yes, sir.

Mr. EVANS. I want to thank this panel. Unless my colleague has any other questions, thank you very much for your testimony here today.

Mr. EVANS. The members of our next panel are Frank Buxton, Dave Gorman, Paul Egan, Dennis Cullinan, Mike Brinck, and Terry Grandison. The entire statement submitted by each member of this panel will be included in the printed hearing record. The subcommittee looks forward to the testimony to be presented by the members of this panel. Once you are seated, we will start with Frank.

STATEMENTS OF FRANK C. BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; PAUL S. EGAN, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA; MICHAEL F. BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE U.S.; TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF FRANK C. BUXTON

Mr. BUXTON. Good morning, Mr. Chairman, and members of the subcommittee. The American Legion appreciates this opportunity to communicate our views on veterans' access to outpatient care in the VA.

There are several issues that impact on the ability of the VA to develop a comprehensive outpatient care delivery system. A major roadblock to the development of a continuum of care as dictated by today's medical practice is the convoluted eligibility criteria for medical care in the VA.

I would like at this point to clarify our position on the entitled group of veterans. When we say service-connected we would include those categories of veterans under existing section 1710(a)(1)

and not just service-connected veterans. That would be the other groups as well: ex-POWs, Agent Orange, and so forth.

Eligibility for care in the VA must be reformed now. Our pleas and those of the other veteran service organizations as well as the VA appear to have gone unheeded. A great deal of time and resources have gone into developing alternative models of eligibility for care which would be effective in solving access problems, but those models seem to have been frozen in time, as so many other important issues have, such as the VA's internal national health care plan, which needs to move forward as well. They are pending the implementation of the national health care reform.

Mr. Chairman, we have been assured by the administration that the VA will remain as a health care delivery system in a reformed national environment. It is time to go to work in putting a sensible, accessible, acceptable and medically sound outpatient eligibility system in place in the VA. The fundamental problems are known. It is time to just do it. Our publication, An American Legion Proposal to Improve Veterans' Health Care, otherwise known as the Gold Book, contains our recommendations for eligibility reform.

Mr. Chairman, the private health care sector has proven that costs can be reduced by delivery of health care in the most appropriate setting and that a major portion of care can and should be delivered in an ambulatory setting. The consumption of expensive inpatient resources to deliver care to veterans who could be cared for in an ambulatory setting just isn't a logical way to render care or, more importantly, to save money.

The VA health care system remains resource driven, using an inpatient model which does not realistically meet the medical needs of this patient population. There is little incentive on the part of the system to move to an ambulatory model such as the private sector has done.

The issue of continuity of care is a most important one. A discretionary care patient with chronic hypertension, for instance, may not be able to access the system for care. However, if we wait for him to have a stroke, his chances of receiving care are heightened for inpatient care. However, he may then not be eligible for follow-up care following this devastating incident.

The VA must shift some existing resources from inpatient to outpatient capability and change the patterns of care accordingly. Mr. Chairman, the travel time and distance are often used as reasons for admitting a patient unnecessarily. Creativity in developing ways to circumvent this issue, such as overnight facilities in or near the VA, are sorely needed. The American Legion has a mandate in place to assist the VA in this effort.

Please allow us, Mr. Chairman, to give the subcommittee some examples of problems with access to outpatient care. At the VAMC in Boise, Idaho, low income Category A patients are restricted from outpatient care for budgetary reasons. The VAMC at American Lake restricts access to the general medicine clinic for the same reason. VAMCs at Phoenix, Prescott, and Puerto Rico have placed restrictions on outpatient care due to severe overcrowding and underfunding. The VAMC at Tampa has waiting times of over six weeks for a routine appointment and up to six months for specialty

care. The VAMC in Orlando is designed and staffed for 50,000 outpatient visits and in fiscal 1992 recorded 104,000 visits.

Mr. Chairman, as we have stated in the past, the American Legion strongly supports the delivery of care in rural areas and in areas where distance makes the use of existing facilities difficult. The implementation and use of mobile, satellite and shared clinic resources must expand now to help resolve the problem of access. This subcommittee, the Congress and the VA must move forward in reforming eligibility and in funding and placement of facilities which make the delivery of quality outpatient care a prime focus.

Mr. Chairman, thanks for this opportunity. This concludes our statement.

Mr. EVANS. Thank you, Frank. We appreciate it.

[The prepared statement of Mr. Buxton appears at p. 71.]

Mr. EVANS. Dave.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. Good morning.

It was interesting to hear virtually each witness from the preceding two panels. Although not saying exactly the same thing, they are certainly consistent in their themes about what seems to be the problem with VA outpatient care.

Mr. Chairman, I would also suggest to you that the manner in which the VA provides outpatient care is in large part inadequate to meet veterans' medical needs and their demand for services. The current manner in which care is provided is inadequate, fragmented, inconsistent and not necessarily geared to what is best for the veteran from a clinical viewpoint, but rather what is necessary from an administrative and budgetary focus.

There are, in our view, two major compelling reasons the VA's outpatient care structure is unable to meet veterans' needs. The first is a lack of clear, consistent and meaningful eligibility criteria, and secondly is the consistent inadequate funding of the VA health care system.

Although, Mr. Chairman, we are indeed appreciative of your efforts in examining various VA health care issues, we cannot help but feel a certain degree of frustration in continuously witnessing disabled veterans' failed attempts to secure adequate VA health care. My point, Mr. Chairman, is simply the pressing need to move forward with efforts to create reform of the VA health care system.

We do not believe, as apparently others do, that movement on VA health care reform needs to necessarily wait for the First Lady's task force recommendations to be made public later this year or, perhaps, into 1994. Rather we believe efforts can now move forward to start VA on the road to reform. The data is available. Seemingly, the interested and the involved parties stand ready to move forward. We are hopeful that a legislative proposal for reform will be forthcoming in the very near future, and we genuinely believe that such a bill could receive favorable action, perhaps during this session of Congress.

Perhaps, Mr. Chairman, no area of VA health care now deserves greater attention than that of outpatient care. It is our belief that the VA medical facilities across the country, when faced with the complex, confusing and ambiguous set of eligibility criteria

compounded by a systemic lack of resources, often make decisions that lead to a denial of care, or more commonly, perhaps, a rationing of care.

Currently this scenario adversely affects a veteran's ability to receive adequate and timely health care services. As one who reads letters from veterans and talks to veterans on the telephone on a daily basis, I feel somewhat qualified to relate the plight of many veterans seeking VA health care services on an outpatient basis.

Without question, the greatest impediment results from the current eligibility criteria. Veterans who are readily admitted for a period of inpatient hospitalization and treatment oftentimes encounter frustrations when attempting to secure physician-ordered follow-up outpatient care. We find many outpatient clinics have backlogs for appointments, with some clinics having a six-month or longer waiting period. Also, follow-up clinic visits are sometimes scheduled much longer than is judged medically proper.

We have encountered numerous instances where certain clinics have been closed to certain categories of veterans and clinics not accepting new patients.

A common complaint voiced by veterans is that block scheduling occurs, when a large number of veterans are scheduled at the same time on the same day to see the same physician.

Another barrier to the provision of adequate outpatient care services seems to be the fact that many facilities lack adequate clinical space. Mr. Chairman, veterans have voiced their sentiments that the intolerably long waiting times experienced in attempting to access VA care has led them to simply give up on the system. When this happens many eligible veterans consciously avoid seeking further assistance from the VA, and as a result many times go without needed medical care services. Clearly this is an intolerable situation also.

To the VA's credit, Mr. Chairman, it is our impression that many VA facilities across the system have instituted a primary care program as their preferred method of delivering outpatient care services. The obvious result is a higher quality of care delivered to the veteran. We encourage and certainly urge the VA to expand in this and other types of innovative care programs. To do so certainly only benefits those who the VA is mandated to serve—the disabled veteran.

That concludes my oral testimony, Mr. Chairman. Thank you.

[The prepared statement of Mr. Gorman appears at p. 77.]

Mr. EVANS. Thank you.

Terry.

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Mr. Chairman and members of the subcommittee, the Paralyzed Veterans of America appreciate this opportunity to express our views on the status of outpatient services at VA medical facilities and the need to clarify eligibility criteria for those services. Mr. Chairman, the status of VA outpatient services is replete with inconsistencies in the selection and treatment of veterans seeking care from the VA. This is primarily due to the fragmented and incoherent eligibility rules which govern the provision of outpatient care.

PVA has for many years advocated that comprehensive eligibility reform is essential to improving the quality, efficiency and accessibility of the VA health care system. Currently, the fragmented eligibility criteria prevents appropriate, cost-effective treatment for the vast majority of veterans seeking care from the VA. Moreover, they counter current trends in modern medicine, which place more emphasis on primary care, prevention and outpatient services.

In addition, this eligibility ambiguity fosters the arbitrary medical selection of patients and services, as well as further inconsistent treatment between regions and facilities within the VA. The lack of a coherent eligibility system leads to inappropriate rationing, delays and outright denial of needed care.

Therefore, PVA recommends the following structure: First, the core group of eligible veterans should consist of service-connected disabled veterans, low income veterans, and special category veterans. In addition, the core group should include veterans who become catastrophically disabled. Two, health care for the core group veterans should be financed through mandatory appropriations. Three, offer a comprehensive benefit package that provides for a full continuum of care—inpatient, outpatient, non-institutional, and institutional and long-term care. Four, offer identical benefits to non-core group members of veterans willing to pay copayments and deductibles to enroll in the VA system. And lastly, collect and hold third-party payments from public and private insurers for all nonservice-connected care to help underwrite the cost of running the system.

Mr. Chairman, that concludes my testimony. I will be happy to answer or respond to any questions that you may have. Thank you.

[The prepared statement of Mr. Grandison appears at p. 82.]

Mr. EVANS. Thank you. Terry.

Paul.

STATEMENT OF PAUL S. EGAN

Mr. EGAN. Thank you, Mr. Chairman. First of all, I think it is important, and it doesn't require an awful lot of repetition based on what the previous witnesses have already said. The eligibility criteria that are applied in outpatient clinics across the country in the VA are certainly disparate, certainly unfair, and certainly create inequities as to who gets care, who gets what services, and they certainly, and perhaps most importantly, are resource driven. I am not sure how that can be solved, but a solution has to be found.

We approach the issue of availability of outpatient care in the same way that we approach availability of health care in the VA generally, and that is with a perspective that assumes that at some point, either late this year, or perhaps next year, or perhaps the following year, that some sort of national health reform program is going to be enacted. And with that in mind, we have to ask ourselves the question that if that is true how without change will the VA fit into that system? And how without change will it survive? And if it doesn't change, the only conclusion that we can reach to both of those questions is it won't and it cannot.

The problems of eligibility for outpatient care are both a microcosm of VA health care generally, and a bellwether of what to expect in the future if change does not come. Mr. Trodden I think is

absolutely right. Change has to come from top to bottom. In fact, we have already suggested to the Vice President that in his effort at reinventing government that he take a look at VA health care as well.

But the problems are clear. VA is consumer unfriendly, unquestionably. The eligibility makes that clear. VA is difficult to get to because of geographic problems and other sorts of problems. Quality is believed by many to be deficient. That may not be true in Iowa City, as the witness from that medical center testified today, but for the most part or at least to a significant part veterans believe the VA treats patients less professionally, less courteously, more invasively, less comfortably, less conveniently, with less privacy and discreteness, and in a less timely manner.

It is foolish to believe in a national health environment that veterans who are currently dependent upon that system will continue to use the system where that is the perception of what they get. Quality in VA is defined today by outcomes, and the people who weigh on in that definition are the medical people, the researchers, and medical school affiliations. There needs to be a greater emphasis on what is the perspective of the consumer because it is indeed in a national health environment going to be the consumer that will constitute the engine pulling the train. If the consumer doesn't use the system, support in the Congress will erode, and the VA may very well find itself going the way of what used to be a veterans' system in Canada. When that country adopted a national health program the veterans system up there disappeared very, very quickly.

We think that it is important for the VA to do some serious thinking, to take some steps in earnest and certainly with some encouragement from the Congress. The Central Office needs to take better control in determining what mix of services are available, what basic services are available at outpatient clinics and in hospitals. The balance between management responsibility between Central Office and local facilities is improper at the present time.

Eligibility reform should be developed, we believe, now as opposed to waiting until after a national health program, so that it can be ready to be brought on line on the first day that national health goes into effect.

The mission of the VA, both its outpatient clinics and hospitals, needs to be quantified in a way that realistically targets those populations of veterans that the VA can take care of, can compete with the private sector, those populations that the VA does a good job with now.

The teaching affiliations, oftentimes are the tail that wags the VA dog and they have to be brought under greater control. At the local level oftentimes the VA's managers of the hospitals are compelled to allow the medical schools a bit too much discretion simply because they rely on those medical schools to provide students and other health care providers. The balance there has to be brought about.

Sharing arrangements for those populations, whatever they might be, that the VA will take care of have to be consummated so that the full continuum of care is provided for those populations for whom the VA will be a provider.

And finally, and I think most everyone would agree, that certainly the VA most assuredly is going to have to be different if it is going to survive, but that does not necessarily mean that it has to be less. And eligibility reform is certainly a very important and certainly well-advised first step in the change that needs to be made.

Thank you.

[The prepared statement of Mr. Egan appears at p. 86.]

Mr. EVANS. Dennis.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the entire VFW membership, I would like to thank you as well as the other members of this subcommittee for inviting us to participate in today's oversight hearing. The lack of access for nonservice-connected as well as medically indigent veterans is a longstanding concern of the VFW. We are very pleased to take part in today's hearing.

The VFW strongly supports immediate liberalization of the eligibility standards which pertain to veterans' health care. This, of course, includes outpatient care. It is our view that the current law establishing veterans' health care entitlement and eligibility is counterproductive with respect to improving the VA system's quality, efficiency and accessibility.

It is well known that veterans' access to VA health care is fragmented and unequal throughout the system. While a given veteran may receive care at one VA medical facility, he cannot get the same care from another. Medically indigent veterans are entitled to inpatient care, but denied outpatient medically care, except for pre- and post-hospitalization visits and to obviate the need for hospital admission.

As is confirmed in the July 1993 draft GAO report addressing the variabilities in outpatient care eligibility and rationing decisions, the standards applied to determine when outpatient care is necessary to obviate the need for inpatient care is vague at best, and applied with absolutely no consistency throughout the VA health care system. The end result of all of this, of course, is denial of care to veterans in need.

We see there being two primary reasons for this unfortunate situation. First of all, is overall lack of resources and funding throughout the VA health care system, and then, of course, the muddled and illogical eligibility criteria which pertain to VA health care and especially to VA outpatient care.

The VFW supports mandated access to all veterans to the VA health care system. This is in keeping with our notions or holdings on eligibility reform. We believe that the so-called core or entitled group should remain to be such. In other words, medically indigent veterans, service-connected veterans, should be entitled to VA health care, and that middle-class nonservice-connected veterans should be allowed to buy into the system, bring along their insurance with them and what money they have. In this way the system would be need or demand driven, as was put earlier, and no longer subject to rigid categories which seem to deny need among the veteran population.

We also support that all veterans who enter the VA health care system be eligible for a full continuum of care. Once again this also includes outpatient care, ambulatory care, primary care, preventive care. We see this to be in keeping with both compassion and with modern medical practice.

Mr. Chairman, that concludes my statement.

[The prepared statement of Mr. Cullinan, with attachment, appears at p. 97.]

Mr. EVANS. Thank you, Dennis.

Michael.

STATEMENT OF MICHAEL F. BRINCK

Mr. BRINCK. Good morning, Mr. Chairman. Thanks for inviting AMVETS here today.

AMVETS as most of the other veterans' service organizations have long held that eligibility reform is key to providing consistent access to the VA medical system. Absent eligibility reform it can only be business as usual regarding access equity problems you have pointed out.

AMVETS along with most of the other veterans' service organizations has been begging for eligibility reform for years. So far only the VSOs have publicly stated their positions on reform. Where is the VA's reform plan? It has been a long time coming. Are we the only ones willing to discuss this most basic issue?

First, the lack of eligibility reform and its attendant inconsistencies in the ability to access VA care is due to insufficient funding from the Congress and successive administrations. The inconsistencies you have addressed in your questions must be laid primarily at the foot of those charged with providing the funds for medical care. It is the Congress' obligation to ensure that VA operates under a basic set of rules that defines the core beneficiary population and provides reasonable access equity throughout the system.

Because of the decreased buying power due to insufficient funds, VA has had to slice the patient pie into smaller and smaller pieces to retain some semblance of order throughout the system. Second, access equity demands that both VA and the veteran know and understand what is required to become eligible for treatment, whether inpatient or outpatient. We are sure that each member of this committee has heard stories from constituents about the difficulties and absurd logic encountered when trying to get into the system.

The current eligibility system is a patchwork of rules that can only be interpreted by someone skilled at reading electrical wiring diagrams. Common sense demands that rules be easily interpreted by both the VA and veterans.

Third, we all know of the 600,000 case backlog in adjudication. Let's not forget the recurring requirement to determine whether additional ailments are service-connected even though the veteran is already in the system. In other words, first, it is hard to get into the system, and once there the rules under which the system operates does not allow the staff to care for the whole person. It is time for the adjudication process to get fixed to ensure that the veteran does not wait six to 12 months before being declared eligible for treatment.

Your questions also raise practical issues that go beyond eligibility and funding. In a system as large as the VA it is probably impossible to grant access to care on an equal basis both within the individual medical center and among the several centers. Variations in staff composition, facility equipment, design, age, location, sharing agreements, medical school affiliations, the amount of volunteer help available, the political influence of its congressional delegation, the aggressiveness of its management and other factors will all cause variations in accessibility. For instance, in addition to staff who specialize in psychiatry, a VA mental health institution may have a small general medical staff to care for its patients. Obviously, veterans in that area will not have the same access to a wide spectrum of medical specialties as those seeking treatment at one of VA's large tertiary medical care centers.

AMVETS continues to support the concept of regionalization and shifting of missions to make the best use of VA resources systemwide. We feel that de-emphasizing the large multi-specialty acute care medical centers in favor of the more numerous satellite and mobile clinics will significantly increase access to care to all but the hardest to serve veterans. And while we continue to support the non-VA fee basis care, limited to those hardest to serve, we cannot support that method of delivery for all veterans because it will destroy the VA system—not just the hospitals, but also the basis for research and development, health professional education and training, and other related entities.

Several of your questions implied that VA was seeing many high income or lower eligibility category veterans at the expense of Category A vets. A review of the 1992 Summary of Medical Programs shows that of the nearly 3 million applications for treatment in the VA system, only a little over 62,000, including about 44,000 inpatient requests, were from discretionary category veterans. That is about two percent of the total. Clearly, VA is not being swamped by discretionary category veterans.

Also, the Survey of Medical System Users Report of 1990 showed that only 30 percent of those treated in VA facilities had employment income and over 54 percent had personal net assets worth less than $20,000. Coupled with the statistics on ages of those being treated, it is clear that the VA's core beneficiary population remains the older and poorest of veterans.

To summarize, AMVETS looks forward to working out an eligibility reform package prior to any other drastic changes in how VA does business, and I would like to say we agree pretty much with what has been defined as the core beneficiary population by the other groups this morning. It is the basic building block along with congressional support of the VA.

And that concludes my statement. Thank you.

[The prepared statement of Mr. Brinck appears at p. 104.]

Mr. EVANS. Thank you very much.

Let me recognize the gentleman from Alabama.

Mr. BACHUS. Thank you, Mr. Chairman. I want to ask a specific question first about block of scheduling, which I think you, Mr. Gorman, brought up.

Have the other organizations run into that same complaint that is about scheduling a number of veterans at the same time for

treatment by the same physician? Anybody want to comment on that? How widespread is that? Because that is the one complaint I am receiving.

Mr. EGAN. Probably, Mr. Bachus, it would depend on what the volume of demand is at a given facility. But demand at all of the facilities with very few exceptions is high.

You raised earlier the point that—well, here we have an example where a population of individuals is willing to accept rationing, but if given a choice these very same individuals representing this very same population are going to vote with their feet. I think we can be most assured of that.

Veterans coming to a clinic for a 10 o'clock appointment seeing a gallery full of people waiting for an appointment at exactly the same time are not for long going to continue to subscribe to that kind of system.

Mr. BACHUS. Have you all made known your concerns about this policy to the VA? And what is their response?

Mr. GORMAN. If I may, Mr. Bachus, I think that a lot of the issues, and we surveyed a number of our national service offices for today's hearing to try to get the complaints that are geographically specific or systemically specific, and quite frankly, the issue of block scheduling along with all of the other problems that we have identified for today's hearing are not new. I mean they have been around for ages. They just continually perpetuate themselves because I think the system is stuck in a rut that they can't get themselves out of, and yet they are sort of forced to be in that rut with no help to get out of it.

Block scheduling, specifically to your question, tends to occur I believe from what we hear more to the point of the specialty clinics being one of maybe a physician—an orthopedics surgeon, for example, might hold clinic one day a week and there are a number of veterans to be seen, then they are all sort of put in at that one day at that one particular time.

I think moving toward the concept of primary care is going to alleviate some of that problem, hopefully.

Mr. GRANDISON. Mr. Bachus, I would basically echo the comments of Mr. Gorman and Mr. Egan. The system is rampant with that type of problem.

And I would also venture to say that these protracted delays in getting treatment is basically tantamount to denial of care. When a veteran patient who needs treatment for a particular ailment is put on a block schedule as mentioned earlier, which would necessarily be a two-week schedule, is put in a 30 block or 60-day schedule, that is basically tantamount to denial of care.

So I concur with Mr. Gorman and Mr. Egan.

Mr. CULLINAN. Mr. Bachus, I would just add that, as you can imagine, within the VFW there have been a number of discussions about the future and the survivability of the VA health care system within the context of national health care reform, and the consensus view is that the biggest hindrance to the success, the future success of the VA is the long waiting lines. I mean it not only constitutes an effective denial of care today, but it jeopardizes the future of the VA health care system.

The one thing I would say, though, on VA's behalf, if you compare waiting lines at VA to a relatively well-heeled private sector hospital it doesn't do very well at all in comparison. But if you compare it to an urban hospital that provides to medically indigent citizens, then it looks a little bit better.

But undoubtedly the lines have to shrink for veterans to be properly served today and for VA to survive.

Mr. BACHUS. Of course, I think at a more well-heeled facility people have a choice. They are not going to wait. They are going to go someplace else.

Mr. CULLINAN. Yes, sir, and they have the money to.

Mr. BACHUS. It just indicates to me a lack of sensitivity.

Mr. BUXTON. Mr. Bachus, what our field representatives find at the hospital is at eight o'clock in the morning the outpatient clinic waiting rooms are already standing room only, and many of the veterans come from far away and they want to get there—even if they have a 10 o'clock appointment, they want to get there at six o'clock to make sure their name is on the list and they are going to be seen.

The fact that they arrive early is certainly not the fault of the VA. But it appears that they arrive early because they know that many times they will wait all day and be told that they can't be seen because too many people have been scheduled and they will be told to come back another time after they may have driven several hundred miles to get to their appointment.

Mr. BACHUS. Of course, you know the VA has an alternative, I would think, of having people call in and a list being made and some people maybe being told "Come at three o'clock, we don't know whether we will get to you." And have a group at eight, a group at nine.

It overwhelmed me when I became a member of the Veterans' Committee and learned that domestic spending on veterans has declined from 15 percent of the total budget to four percent. Now that ought to tell us that it is impossible for us to be getting good quality care with that type of reduction. We have the resource problems, and we have the eligibility problems. We have more veterans, but we don't have the facilities.

But all of that is a given. I think, it is essentially a funding problem and a resource problem. I think part of it is just lack of funds, part of it is lack of allocating resources. But this problem could be addressed just with thought and organization, a good bit of it with absolutely no more expense. I am not sure just what the regulation intended that said we are going to block schedule. I don't know that we should say it is not permitted. I am not sure that, at least, should say that it has to have limitations.

Mr. GORMAN. There is another aspect to it also, I believe, and that is something like the airlines, how they overbook a lot of flights, expecting a certain number of passengers that don't show up. I think probably the same may hold true with the VA.

If I could make one point, and I have thought about this a little bit and I have heard it come up a lot, and that is the choice that veterans have or don't have to use the system and how veterans will not continue to use the VA given national health care reform. I would just suggest, and perhaps the next panel could address it

with more specificity, that the VA is collecting somewhere in the neighborhood of $50 million a month from veterans with third-party insurers. Those are veterans who have health care insurance but yet they continue to use the VA as their provider of care, and there is a reason for that. And there are probably a lot of reasons for that.

So I don't think necessarily that veterans go to VA because they simply have no choice. They do have a choice and they go there in large part because there is quality care delivered. There are aspects and pockets within the VA as there are in any private facility that you get inferior care. But for the most part VA is a quality health care provider, and I think that is evidenced somewhat by this amount of money that is collected—an ever-increasing amount of money that is collected from third-party insurers.

So veterans with choices continue to go and to utilize the VA.

Mr. EVANS. The subcommittee is very concerned about the long waits veterans are facing for outpatient care and we have just received a GAO draft report this morning on this issue. We hope to hold a hearing on this issue in this subcommittee later this year.

I think it is pretty obvious that all of you do not want to wait for Mrs. Clinton's proposal. That you want to move ahead. Is that correct?

Mr. GORMAN. Correct from the DAV standpoint.

Mr. EVANS. You and several other witnesses have talked about a full continuum of care of services. Can you really tell us what constitutes a full continuum of services, in your opinion?

Mr. GORMAN. If I could start, Mr. Chairman, I think it really covers everything from preventive care through hospice care, and those things that the physicians were referring to before—the basic primary health care services to the high tech health care services. And we would include in that, going a step beyond and say that it should include some type of maintenance services of veterans to enable them to remain in their homes as long as they can without expensive medical care having to be provided, especially long-term care. Long-term care does not equate necessarily only to a nursing home bed. It could refer to maintenance and support services by visiting nurses, or in some cases volunteers, to come into the home and provide what is needed to maintain that veteran in the home instead of in the hospital.

Mr. BUXTON. Mr. Chairman, we would concur with that—with Mr. Gorman's evaluation of that situation. We also feel that there are a lot of alternatives to institutional care that are not being explored and not being utilized. We do know that there is an active adult day health care program.

There are a lot of medical care methodologies that could be applied in the home, and I think that would release VA from so many inpatient obligations. A good example is the recent legislation on State veterans' homes being able to provide adult daycare for certain veterans, and any non-institutional form of care, which is much less expensive, would certainly be welcome.

Mr. EGAN. Mr. Chairman, we would define in the area of general practice of medicine that the full continuum of care constitutes what is provided as usual and customary in the private sector. And in addition to that, for special populations of veterans, those things

that are needed to address their special needs. Mr. Buxton referred to some of those. There are some additional special needs that certain populations of disabled veterans have: spinal cord injury, injured veterans, blinded veterans, veterans of that nature.

Obviously, if the full continuum of care in the practice of general medicine was provided to virtually every single veteran who under an eligibility reform program became eligible, it would involve considerable resources, and that is in fact why we emphasize so strongly that in the advent of a national health program there has to be some decision as to what specific populations the VA will treat, and in that decision-making process certain weight has to be given to how well VA is doing in treating special populations today. And where it is doing a better job or as good a job as is done in the private sector it has the best chance of remaining a viable system, and for those populations the full continuum should be provided, in our view.

Mr. GRANDISON. Mr. Chairman, I am basically going to amplify what has been stated. The full continuum of care basically is, once a patient, a core group patient, is admitted to the VA health care system he should have and/or should receive the full spectrum of health care, which may include inpatient, outpatient, non-institutional, institutional and long-term care. But I think the most important aspect of the continuum of care concept is that it is based upon the veteran's health care needs and the factors of fiscal, economic and abstruse eligibility rules are eliminated, and the physicians and the providers of health care can focus on the business of treating the patient in totality, instead of worrying about trying to interpret legalistic language.

So I think what it does at the core is reduce this thing back to the practice of medicine and the treatment of the veteran.

Mr. EVANS. Innovative programs like adult daycare, as it has been called, and at home nursing assistance are to my recollection, and I am not a member of the Hospitals and Health Care Subcommittee, basically being done on a medical center basis without much direction or guidance or support with resources to those local facilities. Is that correct?

In other words, we might be able to reach more veterans if we had some central direction from VA when you are getting into these more innovative areas?

Mr. BUXTON. It has been our experience that it is on a facility level. We recently visited Bay Pines, for instance, and they even provide "Meals on Wheels" for some of their veteran patients. So they are in a position fiscally or have used some ingenuity to come up with some of these things that would help veterans at home and keep them from coming into the institution.

Mr. EVANS. Are VA administrative decisions denying access to care being appealed by affected veterans?

Mr. GORMAN. I don't think I can answer that specifically. We could provide that for the record through our national service department, if you like.

Mr. EVANS. I would appreciate that.

Do you know if veterans are routinely being informed of their right to appeal these decisions?

Mr. BUXTON. We certainly believe that is getting better. But it is at the adjudication level where the veteran's level of disability is adjudicated. Certainly, the appeals process and due process are in place and being enhanced. The Court of Veterans Appeals has certainly improved that process. The VA may not agree with that completely because of the backlog of remands it has created.

But I think that the appeals process is basically at the adjudication level or at the Board of Veterans' Appeals.

Mr. EVANS. I would appreciate it if you would submit in writing, the experience each one of your organizations has had with appeals of VA administrative decisions which denied veterans access to care.

[The American Legion response to request of Chairman Evans follows:]

1. I would appreciate it if you would submit in writing, the experience each one of your organizations has had with appeals of VA administrative decisions which denied veterans access to care.

Response: When a veteran is denied care by an administrative decision at the local facility level, that veteran has a right to appeal at the facility level and through the Board of Veterans Appeals. It is unclear whether the veteran is informed of his right to appeal under VA's "duty to assist" on a regular basis. However, there is a standard VA form which should be attached to the denial informing the veteran of his/her rights to appeal.

We occasionally receive complaints that veterans are denied care because of some bad judgment calls at the facility. Only about two of these complaints reach the level of VA Central Office per year and are presumably resolved to the veteran's advantage. There is an additional avenue of appeal through the Board of Veterans Appeals which is rarely pursued. The VA Medical Center has the obligation to prepare a "Statement of the Case" for the veteran setting forth the reasons and bases for denial of care with a copy to the Veteran's representative, if applicable.

The American Legion and other veterans service organizations have attempted to attain eligibility reform for VA health care for years to assure that no veteran in need of care is denied such care. It is imperative that such reform be included in any plan to reform health care at the national level. The Health Security Act amended by H.R. 4124, includes acceptable reformed eligibility guidelines. A watchful eye must be kept to assure that eligibility for care remains fair and equitable in any health care reform legislation and that the continued right of appeal is assured.

Mr. EVANS. Does the gentleman from Alabama have any other questions?

Well, I thank this panel very much, and appreciate your work. Thank you.

Mr. EVANS. Our final witness today is Wayne Hawkins, Deputy Under Secretary for Health for Administration and Operations, the Department of Veterans Affairs. Wayne, if you will come forward now, and we will ask you to introduce the representatives of the DVA that are accompanying you today.

STATEMENT OF C. WAYNE HAWKINS, DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATION AND OPERATIONS, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ELWOOD HEADLEY, M.D., DEPUTY ASSOCIATE CHIEF MEDICAL DIRECTOR FOR AMBULATORY CARE, VETERANS HEALTH ADMINISTRATION; W. KENNETH RUYLE, DIRECTOR, MEDICAL ADMINISTRATION SERVICE, VETERANS HEALTH ADMINISTRATION; AND CHARLES A. MILBRANDT, ACTING ASSOCIATE CHIEF MEDICAL DIRECTOR, RESOURCES MANAGEMENT, VETERANS HEALTH ADMINISTRATION

Mr. HAWKINS. Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss VA's outpatient care programs.

With me today are Dr. Elwood Headley, the Deputy Associate Deputy Chief Medical Director for Ambulatory Care; Mr. Kenneth Ruyle, the Director of Medical Administration Service; and Mr. Charles Milbrandt, the Acting Associate CMD for Resource Management.

VA provides a wide range of services to veterans through its ambulatory care programs. Outpatient services are provided at 170 medical center outpatient clinics, 53 satellite clinics, 44 community-based clinics, 81 outreach clinics, seven independent clinics, and six mobile clinics. VA also provides outpatient services through its home care, homeless and counseling programs. Where VA facilities are not accessible to veterans with a high priority claim to service VA contracts for services in the local community.

In fiscal year 1992, veterans made over 24 million outpatient visits, of which 23 million were visits to VA facilities and one million were contract, fee-basis visits. The total cost of outpatient care in fiscal year 1992 was $3.7 billion, which is about 28 percent of the medical care appropriation. The President's 1994 budget request includes funding to support 24.9 million outpatient visits.

Mr. Chairman, Public Law 100–322, the Veterans' Benefit and Services Act of 1988, provided that outpatient medical services shall be furnished to certain veterans, and may, at the discretion of the Secretary, be provided to other veterans to the extent resources and facilities are available in accordance with specified criteria. We have provided a description of current VA outpatient eligibility rules including priorities for access to care.

Since 1988 VA medical centers have been applying the provisions of this legislation while dealing with resource constraints. Over time and in accordance with the intent of the law VA medical centers have been required to reduce the amount of care being provided to "discretionary" veterans. Although there is regional and national oversight of workload distribution, VA medical centers must make decisions about restricting workloads based on availability of funds at their own facility.

Management decisions regarding a decrease in the discretionary workloads are based on the requirements of the law and on the budget analysis of the available funds in conjunction with a mix of patients being treated, the utilization of programs offered, the available human resources and their cost, and use of other funds

in the medical center. These decisions are based on a multitude of factors at each medical center.

During 1992 VA established networks of hospitals and clinics to improve the delivery of services to veterans, to promote coordinated planning among medical facilities within geographic regions, and to optimize resource utilization. This initiative in addition to the new resource planning and management methodologies that are now being implemented in fiscal year 1994 over time should significantly improve the allocation of resources to equate more evenly with the case mix of the individual medical centers. These initiatives will lay the groundwork for a much greater emphasis on managed care within the VA system where health care will be provided in the most appropriate setting to meet the patients' health care needs.

Mr. Chairman, we have reviewed two recent GAO reports that address consistency of VA medical centers' determination of eligibility for care and variations in the provision of care. While the degree of variability found is not desirable, we believe it is to be expected given the current resources available and the rules and laws that currently govern access to care. We expect that the full implementation of VHA's resource planning and management system and networking of hospitals will reduce differences in access to care among medical centers.

This concludes my statement, Mr. Chairman. I and my colleagues will be happy to respond to the committee's questions.

[The prepared statement of Mr. Hawkins, with attachment, appears on p. 108.]

Mr. EVANS. Thank you.

Let's start with determining, in your opinion, what the relationship is, if any, between eligibility reform and national health care reform.

Mr. HAWKINS. Well, we certainly have listened very carefully this morning to the eligibility reform issues that have been raised by our colleagues in the field, and certainly veteran service organizations and certainly the points that they have brought up, and the GAO study is an area that we certainly have agreed in principle with in terms of how to reform the eligibility to make it simple, to certainly make it understandable, and to be able to provide care on a medical basis as opposed to an administrative basis, and also in the proper setting.

Mr. EVANS. As I said earlier, national health care reform may take months for Congress to study, it may not go into effect for years. Once it does go into effect, if the VA wants to be a competitive player in that new field of medicine, in that new arena, you might say, if it has a bad image because of long waiting lines or because veterans have been confused, that is going to affect its competitiveness in that new health care reform area. So I would urge you to closely examine this.

The veterans' groups want eligibility reform just as quickly as possible, and I hope we can get it soon. We said that we would be looking into the issue of long waiting lines in a hearing sometime in the fall, and that, obviously, is of great interest to us.

According to the Department, eligibility reform is essential to significantly improve consistency in VA-provided outpatient care. How

will eligibility reform achieve consistent decisions among the thousands of decision makers at the hundreds of facilities the VA has?

Mr. HAWKINS. Well, Mr. Chairman, as you know, the Secretary is one of the members of the President's health care reform group, one of the six Secretaries at the White House that have been working on this. We have had about 30 of our employees within the VA system working on various task forces on health care reform. We have made available to them the data that we have worked on for a couple of years on reform alternatives to educate the other people on the health task forces that are going to recommend the Nation's reform proposals.

Also, we have laid out what we think would be the kind of health care reform that we in the Veterans Administration would like to see, and I think the Secretary in the last few days has indicated certainly what he anticipates may come out of that, even though we don't have the VA's full plan yet.

But certainly I think what has to be an important element of that is a system that will make us not only competitive but certainly a system that veterans will choose to come to in terms of the other systems, and will address the issues like continuity of care, waiting times, and certainly the other issues that will have to be addressed to make us competitive to the system.

Mr. EVANS. Are you familiar with the Legion and VFW proposals for eligibility reform?

Mr. HAWKINS. Somewhat. Not in detail.

Mr. EVANS. Can you comment on it in your response today?

Mr. HAWKINS. Well, I think we have been working with the VSOs on various proposals. We have certainly looked at various proposals and the input that they have had regarding our VA health care reform proposals the last couple of years. I think overall that what the Secretary is proposing is consistent with what a lot of the organizations are proposing, and what the Secretary has said in the last few days is that some of the provisions or features of a reform plan would be for service-connected and low income veterans and those that we currently call Category A, that if they choose to receive their care in the VA that they would receive the standard package of benefits plus other care and services, which would amount to the full continuum of care, and for those who choose to receive their care from the VA there would be no premiums or deductibles or copayments. And that those who receive care or would want to receive care from non-VA providers they would be limited to the standard package, whatever that might be, but still would be eligible for the VA additional kinds of services that were available.

The Secretary went on to say that under a reform plan that he would like to see those veterans who are not now included in that category, be given the opportunity of choosing the VA. Under this approach the VA would be authorized to collect and retain reimbursements from private third-party insurance, Medicare and other sources. So I think in that sense the Secretary has enunciated some of the thinking that is coming out of the reform task force and his position is somewhat similar to the service organizations.

Mr. EVANS. Third-party reimbursement for service-connected problems is a contentious issue in the budget reconciliation process

at this point. Is that what you are calling for in terms of the Secretary's plan?

Mr. HAWKINS. No. I think his plan would be that service-connected veterans would not be asked to pay anything.

Mr. EVANS. What services, in your opinion, constitute the full continuum of care?

Mr. HAWKINS. Well, as was defined before—and Dr. Headley might want to comment on this from the physician's standpoint, we have viewed a full continuum from preventive which could include home health care to outpatient care to acute high tech care to long-term care and to hospice care. Again, I think it is important to be able to provide that continuum in the right setting, which not only makes it a better quality but certainly more efficient and more timely.

Dr. Headley, do you have any comments on that?

Mr. HEADLEY. No. I believe the continuum of care has been very well covered this morning and was just restated by you. I think that we are pretty much in agreement that it would cover outpatient care for acute and chronic bio/psychosocial conditions. It would cover the provision of preventive health care interventions. It would cover referral for inpatient care or more complex levels of care as indicated, and then a return to the outpatient care for overall care management when that care episode had been completed. And it would, in addition, include long-term care interventions such as have been mentioned, including inpatient and outpatient long-term care interventions.

Mr. EVANS. I yield to the gentleman from Alabama.

Mr. BACHUS. Mr. Hawkins, you have heard some of the veterans' organizations express some frustration in that the VA has not announced an eligibility reform proposal. And, as I think Chairman Evans said, these organizations have come forward with their own proposals on eligibility. I think you said you are somewhat aware of them?

Mr. HAWKINS. Yes.

Mr. BACHUS. I guess my question is just when is VA going to announce its own eligibility reform proposal? Everyone has agreed there is a need for it for at least two years. Are you waiting on the national health care reform? Are you being held back?

Mr. HAWKINS. Well, the Secretary, as I mentioned, is a member of the President's board that is looking at national health care reform. He wants to be sure that the VA role is defined by the White House task force and then that our eligibility reform is consistent with those plans. I can assure you, sir, that the VA has been working very closely with the health care reform task force. We have made our data available to them. And I think that we are prepared to move as soon as the Secretary feels it is appropriate to move based on the total White House task force recommendations.

Mr. BACHUS. Mr. Hawkins, I guess what I am saying here is the veterans are being penalized by the delay in health care reform. I don't see that there is any justification for making eligibility reform within the VA and trying to see that it somehow does not conflict with health care reform for the general public. And I say that because the health care that veterans were promised—some of them were promised back in World War I. This is not anything to do

with the present proposals to offer national health care. Veterans' health care is basically a commitment this Government made to them years and years ago when they served. I am afraid they are going to be thrown into national health care and treated as "equals" with everyone else when our obligation to them is greater than our obligation to the general public, because we have a specific commitment to them to supply this treatment.

I hear statements like "We want to make sure veterans receive the same type of care that everyone else is going to be afforded," when really the care that we give them ought to be at least first. It ought to take priority. And yet they are being held back by the proposals for national health care.

Let me ask you this question. Do you have an eligibility reform proposal or does VA have one today that they could announce? Are we just waiting on something from the White House or something on national health care?

Mr. HAWKINS. Not at all, Congressman. The Secretary has two or three task forces working on the various parts of the national health care reform for the VA. We have a managed care task force. We have one that deals with eligibility reform. And we are prepared to move toward as soon as the Secretary's decision is made.

I can assure you that we do not intend to delay moving forward in this area, but I do think it is important that we know how the VA is going to fit into the national health care reform picture. And certainly I would agree with you that our veterans, and I think the President has so stated, that the veterans' programs and system will be retained as a separate program. And we want to be able to provide the kind of care that our veterans need, and as you say, deserve, and we would agree totally with that.

And we are prepared to move forward as soon as we are able to make those decisions.

Mr. BACHUS. Do you think there is an appreciation by the administration that this commitment to supply veterans' health care predates and is superior to any commitment we have to the general public to supply health care?

Mr. HAWKINS. Well, the statements that have been made by the President as well as Mrs. Clinton indicates very strong support for the VA system and our commitment to the veterans.

Mr. BACHUS. Give me your best guess as to when we are going to have an eligibility reform proposal from the VA.

Mr. HAWKINS. Well, according to all indications, and according to the Secretary's statement just two days ago to the Senate committee, we expect to receive the White House task force proposals sometime early this fall.

Mr. BACHUS. Now, that is on national health care.

Mr. HAWKINS. And I would think that following that then the VA would be in a position to immediately move forward with their recommendations.

Mr. BACHUS. So we are actually—what you are saying is we are going to wait on the national health care proposals to determine what kind of eligibility our veterans have for care at the VA hospital?

Mr. HAWKINS. Well, I think VA's proposal has to be looked at in conjunction with the Presidents' National Health Reform proposal.

The Secretary does have options as to what the timetable for VA's eligibility reform. But those discussions are going on daily right now with the Secretary in terms of those options.

I know he feels very strong that we should be planning based on what the current needs are for the VA system in terms of the continuum of care, the economic impact this is going to have on the total budget, and the collection of third party dollars. We will have to make investments up front to be able to increase access and to enable us to have patients enter the system more conveniently, and to address the backlogs in the outpatient clinics.

So it is not an easy task to just reform eligibility without looking at the economic impact as well as the facility impact, the staffing impact, and then basically any proposals that deal with treating other kinds of veterans who are not service-connected or poor, the Category A patients, and deal with any reimbursements and what happens to those reimbursements.

Mr. BACHUS. Do you see that our obligation to the veteran is independent of the administration's health care proposals for the general public?

Mr. HAWKINS. Well, I think the laws that are now written makes it very clear, and until those laws are changed, I think we definitely have a commitment to fulfill those laws that Congress has passed to provide services to our veterans.

Mr. BACHUS. Do you think that part of the administration's health care proposal ought to be that our obligations to veterans are in no way diminished?

Mr. HAWKINS. Very definitely. I think that is certainly one of our feelings. That veterans have special needs that sometimes are not always available in the private sector, like blind rehab, spinal cord injury, PTSD, where we are the leaders in those fields. And we do have some concerns that whatever reform takes place that those special needs of our veterans are met.

Mr. BACHUS. Let me say this. If we have veterans and know what we are going to do for our veterans, and then we have national health care, aren't we better off if we go ahead for our veterans and set eligibility, and then let the national health care proposals adjust themselves to what we have said as opposed to waiting on their proposal and trying to let them dictate to us what we are going to do for veterans? Why don't we step forward and say this is the service and the benefits and the health care we are going to deliver to veterans and let national health care amend their proposals?

Mr. HAWKINS. Well, I think under the national health care plan veterans will have a choice. And I think certainly from the VA's perspective we need to know the details of the National Health Care plan so that VA's proposal adequately considers the impact of that proposal on veterans.

Mr. BACHUS. Now, I am not talking about a choice. I'm talking about eligibility for veterans to get health care and I don't think it ought to be affected by the health care task force. I think our obligation to our veterans came first and ought to precede their proposal. I think we ought to be telling them this is what our veterans have earned, and I think it ought to be our eligibility proposal. I think we ought to go ahead and announce that plan now.

Mr. HAWKINS. Well, the Secretary is looking at those options now, sir, and I can't tell you what his decision will be. But I am sure that he intends to do that as soon as possible. And, as I mentioned earlier, we have been working on this for quite sometime now and we are not just sitting and waiting for the health care reform to come forward. We do have several plans that could be implemented based on the decision of the Secretary.

Mr. BACHUS. Well, I would urge you to go ahead and announce an eligibility reform proposal. I would also urge you to not let the administration's health care reform dictate to the VA or to veterans as to what kind of care they will receive but that we be an advocate for the veterans and that we say to them we have already made an obligation to veterans and when you start allocating the money the first money you allocate is to take care of commitments that we have made years ago to our veterans. And when money is left over after those commitments that goes to the general public.

Mr. HAWKINS. Any proposal that we develop would have to come, you know, to Congress for approval because that is the law at this point, and we are prepared, again based on the Secretary's decision as to the appropriate time to do that. We will be in a position to move rapidly once his decision is made.

Mr. BACHUS. Well, I would urge you to urge him to go ahead and make that decision and announce that proposal and to try to dictate to the administration. I just see the veterans as waiting around to see what they are going to receive and I don't think they should be in that position. I think that commitment is there, it has been made, and they ought to get that care. And once we determine how much money that is going to cost, then we know how much money is available for national health care for our other citizens.

Thank you.

Mr. EVANS. Thank you. I want to thank this panel. We will submit additional questions to you, and your answers to those questions will be made part of the record.

I also want to thank the gentleman from Alabama for his participation. It has been very useful. It is three hours out of his schedule. We thank you very much.

Thank you all and with that we will adjourn the hearing.

[Whereupon, at 11:32 a.m., the subcommittee was adjourned.]

APPENDIX

Statement of
Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations

Veteran Access to VA Outpatient Health Care
and Related Issues

July 21, 1993

Good morning and welcome. Today the Subcommittee on Oversight and Investigations is examining veteran access to VA provided outpatient care.

As we all know, each VA facility is unique; no two VA medical centers are entirely alike. VA medical centers differ in location, equipment, services provided, staffing, top management style, employee morale and of course patient satisfaction.

While many of these differences are really not surprising, VA facilities would be expected to be more nearly alike in other ways -- including veteran eligibility for outpatient care. VA decisions on which veterans are given access to outpatient care and the types of care these veterans receive should be alike or consistent from VA to VA and especially within the same VA facility.

This issue is critically important because, as we will learn in some detail today, access decisions determine if or when veterans receive care and the types of care they will be given.

Through visits with veterans and their family members and other visits to VA medical facilities, this Subcommittee has become concerned about possible wide variations in VA outpatient access decisions.

Some months ago, the Subcommittee asked GAO to examine this fundamentally important issue. Today GAO will present what it has learned.

Unfortunately, my suspicions about inconsistency in veteran access to VA outpatient care have been confirmed.

The outpatient care provided by one VA facility, may be denied by another.

Care provided today, may not be provided tomorrow.

Even at the same VA center, a veteran may be given treatment for one nonservice-connected condition, but denied care for another.

When providing outpatient care is based on discretion, the inescapable result is inequity in veteran access to health care.

Inconsistency, in fact, may be the most consistent aspect of VA outpatient care eligibility decision-making.

Because eligibility and access decisions may be constantly changing, veterans, understandably, can be confused and sometimes bewildered or upset about VA outpatient services. In some cases, there appears to be no "system" in the VA health care system, particularly in eligibility criteria interpretation.

Certainly, managing a VA medical center is challenging. This challenge becomes even greater and more difficult when resources are less than desired. Differences in judgment and management style also exist. But do these factors excuse inequitable treatment? Should they?

In addition to examining the variations, or perhaps aberrations, which veterans confront day-in and day-out as they seek access to VA outpatient care, GAO was also asked to review the consequences of VA denial of outpatient care to veterans.

These are the issues we hope to learn more about today.

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United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

For Release
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July 21, 1993

VETERANS AFFAIRS

Accessability of Outpatient Care at VA Medical Centers

Statement of
David P. Baine, Director
Federal Health Care Delivery Issues
Human Resources Division

GAO/T-HRD-93-29

SUMMARY

GAO recently issued two reports addressing veterans' access to outpatient care at the 158 medical centers operated by the Department of Veterans Affairs (VA). GAO found that veterans with similar medical conditions or economic status were receiving care at some centers but not at others. As a result, veterans were frequently confused or frustrated when they were turned away by VA centers without receiving needed medical care.

VA medical centers' interpretations and use of statutory eligibility and rationing criteria varied widely for two reasons. First, because of inadequate VA guidance, medical center staff, too often, rely primarily on subjective judgments when deciding who is eligible for outpatient care. Second, consistent with VA's decentralized management philosophy, medical center staff make rationing decisions based on locally developed policies.

GAO recommended that the Secretary of Veterans Affairs propose to the Congress alternative eligibility criteria that produce more predictable eligibility decisions or provide better guidance to centers so that physicians may make more consistent eligibility determinations. GAO also suggested that the Congress consider whether to direct the Secretary to modify VA's system for allocating resources to medical centers so that veterans with similar medical or economic status are, to the extent practical, provided more consistent access to outpatient care.

VA reviewed GAO's draft reports and generally agreed with the findings and conclusions. VA officials recognize that inconsistencies exist in veterans' access to care systemwide and have indicated a willingness to implement corrective actions as GAO recommended.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss veterans' access to outpatient care at the 158 medical centers operated by the Department of Veterans Affairs (VA).

In recent years, witnesses testifying before both this Subcommittee and the House Committee on Veterans' Affairs have questioned whether veterans have access to VA health care when they need it. In response to these concerns, you asked us to examine (1) how VA determines veterans' eligibility for outpatient care, (2) how VA rations such care, and (3) what happens to veterans who are turned away.

As you know, veterans' eligibility for VA outpatient care, by law, is based primarily on a veteran's medical condition or status during military service. Veterans are entitled to receive care for disabilities related to military service. Their eligibility for treatment of conditions unrelated to service disabilities generally depends on whether care is required to "obviate the need for hospitalization". VA may ration care when resources are not sufficient to serve all eligible veterans; consequently, eligible veterans may be turned away without receiving needed medical care for nonservice-connected conditions. Generally, those with the highest incomes are to be turned away first.

As we recently reported to you, VA medical centers' interpretations and use of statutory eligibility and rationing criteria vary widely. As a result, veterans with similar medical conditions or economic status are receiving care at some centers but not at others. Unfortunately, Mr. Chairman, we are unable to tell you--from a systemwide perspective--how many veterans are turned away from VA medical facilities. This is because VA's management systems do not include reliable information on those veterans who leave VA facilities without receiving needed care. We can tell you, however, that VA's current eligibility and rationing practices, too often, confuse and frustrate veterans.[1]

While totally consistent application of any eligibility criteria is difficult, if not impossible, to achieve, we believe that VA medical centers should become more predictable in their eligibility decisions. Currently however, because of inadequate VA guidance, medical center physicians are relying primarily on subjective judgments when deciding who is eligible for outpatient care. We recommend that the Secretary of Veterans Affairs either develop and propose to the Congress an alternative eligibility criteria which produces more predictable eligibility decisions, or provide better guidance to centers so that physicians may achieve more consistent determinations when interpreting the current criteria.

Consistent with VA's decentralized management philosophy, medical center staffs are making rationing decisions based on locally developed policies. However, it is unclear whether the Congress intends that rationing decisions be made on a local or systemwide basis.

From a veteran's perspective, it seems preferable that VA develop a strategy to deal with resource shortfalls on a more equitable basis systemwide. Therefore, we suggest that the Congress consider directing the Secretary of Veterans Affairs to modify VA's system for allocating resources to the medical centers. Resources should be allocated so that veterans with similar economic status or medical conditions are, to the extent practical, provided more consistent access to outpatient care.

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[1]VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care from Alternative Sources (GAO/HRD-93-123, July 1993).

Now I would like to describe, in more detail, the variabilities in medical centers' eligibility and rationing practices and veterans' efforts to obtain needed medical care elsewhere when VA centers do not provide it.

SUBJECTIVE ELIGIBILITY JUDGMENTS CAUSE INCONSISTENT ACCESS TO CARE

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

> "... shall be based on the physician's judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated, would reasonably be expected to require hospital care in the immediate future..."

To assess medical centers' implementation of this criterion, we used medical profiles of six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations. At these 19 centers, interpretations of the criterion ranged from permissive (care for any medical condition) to restrictive (care only for certain medical conditions).

For example, five centers used a permissive interpretation and determined that all six veterans would be eligible for outpatient care. In contrast, three centers interpreted the criterion more restrictively and determined that only two veterans would be eligible for care. The other 11 centers used more middle-of-the-road interpretations.

From a veteran's perspective, such varying interpretations mean that their access to VA care will depend greatly on which center they visit. For example, none of the six veterans was consistently determined to be eligible or ineligible for care by all 19 centers; that is, each of the 6 veterans would be eligible for care at some medical centers and ineligible at others. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others. In contrast, another veteran would have been eligible at all but 2 of the 19 centers.

Officials at VA's headquarters and medical centers agreed that the "obviate the need for hospitalization" criterion is an ambiguous and inadequately defined concept. A headquarters official stated that, because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

> "... is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation... Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office..."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

LOCALLY DEVELOPED RATIONING POLICIES CAUSE INCONSISTENT ACCESS TO CARE

The Congress established priorities for VA to use in providing outpatient care when resources are not available to care for all veterans. VA has delegated rationing decisions to its 158 medical

centers; that is, each must independently make choices about when and how to ration care. However, VA does not systematically monitor medical centers' rationing procedures or practices.

Using a questionnaire, we obtained information from VA's 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected conditions and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demand for VA care. Of the 118 centers,

-- 69 rationed care only to higher income veterans,
-- 27 rationed care to higher and lower income veterans, and
-- 22 rationed care to higher and lower income veterans, as well as those who also have service-connected disabilities.

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are served or turned away.

The 158 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within the centers. For example, higher income veterans frequently received care at many medical centers, while lower income veterans or those who also have service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower income veterans who needed certain types of service while caring for higher income veterans who needed other types of service.

VA could reduce such inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic make-up of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from the 40 medical centers that had sufficient resources and therefore, did not ration care in 1991. Such resource shifts could mean, for example, that some higher income veterans at those centers might not obtain care in the future. But, it could also mean that some veterans with lower incomes who had not received care at other medical centers might receive care in the future.

MOST VETERANS GAO SURVEYED OBTAINED CARE FROM ALTERNATIVE SOURCES

As you requested, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it. To do this, we visited 6 medical centers and identified 198 veterans who applied for care during the first 6 months of fiscal year 1992 and were turned away without receiving all needed care.

We selected the centers and the veterans judgmentally because VA's management systems do not maintain reliable information on veterans who did not receive needed care. This information could be obtained only through discussions with officials at medical centers and reviews of veterans' medical and administrative records. Because of these data limitations, our work provides a "snapshot" view of what happened to the 198 veterans, but it cannot be applied to other veterans seeking outpatient care at the 6 centers or at other centers nationwide.

Through discussions with the 198 veterans, we learned that 85 percent obtained needed care after VA medical centers turned them

away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center. Inability to pay was most often cited by veterans as the reason they did not obtain care elsewhere. The 198 veterans surveyed needed varying levels of medical care. Some requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

VA staff face difficult medical and administrative choices each time they consider turning away a veteran needing care. Should they provide all diagnostic testing, knowing that the tests are likely to be repeated wherever the veteran goes to get care? Or should they minimize the tests provided, knowing that they will be unable to provide care, if needed? VA centers exercise wide latitude in making these decisions when providing outpatient care to veterans.

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In summary, Mr. Chairman, veterans are too often being made to feel like they are participating in a health care lottery where their chances of receiving care are heavily dependent on which center they visit, which physician examines them, or which day of the year they need care. As a result, veterans are understandably confused and frustrated about whether they will receive VA care when they need it.

Physicians, too, are uncomfortable with the current system. They continually have to decide whether to deny care to veterans before determining how best to meet veterans' medical needs. Too often, physicians are required to judge, without adequate guidance, whether veterans' conditions will, if left untreated, deteriorate and result in hospitalization. This places physicians in a very unenviable position--relying on subjective judgments to make difficult eligibility decisions or ignoring statutory requirements in order to serve veterans' needs.

VA is credited with operating the nation's largest health care system. However, the widespread inconsistencies in veterans' access to outpatient care at VA's 158 medical centers suggests that the centers are operating more as independent providers than as integrated components of a nationwide system. While serving in the military, veterans operated under a consistent set of rules that were, for the most part, clearly understood. It seems reasonable for veterans to expect that VA's delivery of health care benefits earned as a result of military service should operate in a similar manner.

As you know, Mr. Chairman, VA reviewed our draft reports and generally agreed with our findings and conclusions. VA officials recognize that inconsistencies exist in veterans' access to care systemwide and have indicated a willingness to implement the corrective actions we have recommended. In general, VA plans to provide an eligibility reform proposal for consideration by the Congress and, in fiscal year 1994, to implement a new resource allocation process--actions that VA officials believe will address the types of service variabilities we found.

This concludes my prepared statement. We will be glad to answer any questions you and members of the Subcommittee have.

STATEMENT OF MR. STEPHEN A. TRODDEN
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
U.S. HOUSE OF REPRESENTATIVES
VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ON
VETERANS' ACCESS TO VA OUTPATIENT HEALTH CARE
JULY 21, 1993

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the actions which the Office of Inspector General (OIG) has taken to review and improve veterans' access to Department of Veterans Affairs (VA) outpatient health care services.

Between 1990 and 1992, my office issued three national audit reports specifically addressing veterans' access to and eligibility for VA outpatient health care. The audits were conducted to determine the effect of new outpatient eligibility provisions contained in The Veterans Benefits and Services Act of 1988 (Public Law 100-322), and the Veterans Health Administration's (VHA's) compliance with that statute. As part of these audits, we were also interested in reviewing VHA's actions to achieve the goal of providing veterans with uniform access to outpatient care.

I. Audit of the Implementation of the Outpatient Entitlement Provisions of Public Law 100-322 (Report No. 0AB-A02-049, March 1990)

The first audit was conducted to evaluate the effect of a 1988 VHA policy decision to apply the law's "mandatory" and "discretionary" eligibility categories as a means of reducing the availability of outpatient services to some veterans and, thus, equalize access to care among geographic regions. The audit included an in-depth analysis of the data systems used by VHA to collect and report outpatient workload. We found that the number

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of outpatient visits declined 7 percent nationwide in the first 6 months following implementation of the policy; however, we concluded that these reductions did not result in more equal access to outpatient care. Instead, we found that VHA's policy of measuring access rates, based on separate visits and among large geographic regions, only served to permit variation and misreporting of outpatient workload data by medical centers.

We recommended that VHA measure access rates based on individual patients, rather than on patient visits, and that comparisons of access rates be made on a State-by-State basis, rather than by large geographic regions, in order to improve the precision of workload and resource adjustments. Although the Under Secretary for Health did not initially concur with the recommendations, he subsequently agreed that individual patients would be used as a basis for workload and resource allocation decisions. He also informed us that he would do more than we recommended by providing for equity of access adjustments at the medical center level, not State-by-State. At this time, VHA continues the process of implementing these recommendations, and my office is monitoring the status. VHA has reported to us that full implementation should be completed during Fiscal Year 1994.

II. Audit of the Outpatient Eligibility and Entitlement Provisions of Public Law 100-322 - Implementation at the Facility Level (Report No. 0AB-A02-081, July 1990)

The second audit was conducted to determine the effect of VHA's workload reporting policies on the ability of medical centers to properly identify their outpatient workload by eligibility group, and the impact of any misreporting on veterans' access to outpatient care. The audit included a detailed assessment of reported workload, and actual workload as defined under the law, at a VHA independent outpatient clinic. We concluded that VA's outpatient workload reporting systems did not allow the Department to monitor veterans' access to outpatient care based on the eligibility groups defined in the 1988 law. We found that, although VA was reporting that over 90 percent of its outpatient workload was mandatory, only slightly over half (52 percent) was mandatory under the statute.

As a result, VHA was unable to allocate resources among VA medical centers equitably, based on their actual proportions of mandatory outpatient workload. In human terms, this has to result in some nonservice-connected veterans being denied care while other veterans receive care (at the same and other VA medical centers) for similar or less severe nonservice-connected conditions. Simply stated, there were variations in the definition and/or enforcement of VHA's policy on eligibility for outpatient care at the facility level.

We recommended that VHA identify the workload associated with treating the nonservice-connected conditions of veterans rated less than 50 percent service-connected disabled. The Under Secretary for Health agreed with the recommendation and VHA has reported to us that the system which will implement this process is scheduled for activation on October 1, 1993.

We also recommended that VHA identify the workload for treating nonservice-connected veterans whose incomes exceed the levels established by the law for mandatory treatment. This recommendation has been reported by VHA as implemented.

III. Audit of the Outpatient Provisions of Public Law 100-322 - National Workload Planning and Budgetary Implications (Report No. 2AB-A02-059, March 1992)

Based on the request of the Under Secretary for Health, the third audit was conducted at another VA outpatient facility associated with a highly affiliated, tertiary care medical center in order to determine whether our findings of misreporting outpatient workload were systemic. The results of this audit confirmed our earlier findings. We also used this audit to assess the national planning and budgetary impact of VA's misreporting of outpatient workload. We concluded that, because of the misreporting, VA was not in compliance with the eligibility provisions of the 1988 law and was unable to allocate its resources to provide veterans with uniform access to care based on the priorities established by the law. We also concluded that the single biggest impediment to full compliance, and consistent application of eligibility rules, was a lack of specific policy guidance addressing the conditions and

circumstances under which outpatient treatment may be provided for nonservice-connected illnesses which would "obviate the need for hospitalization."

Our review found that, although the "obviate the need..." criterion has been central to the eligibility determination process for outpatient care within VA since 1973, it has never been adequately defined for use by clinical staff. As a result, we found that the criterion was either ignored, perfunctorily applied to every application for outpatient care, or inconsistently applied depending on which physician examined the patient.

We recommended that VHA develop regulations that address the conditions and circumstances under which outpatient treatment may be provided to "obviate the need for hospitalization." The Under Secretary for Health responded that the criterion was impossible to define and apply at the clinical level; and that VA efforts to reform eligibility law for health care would, if successful, make the recommendation unnecessary. The issue was referred to the then Deputy Secretary for resolution, and in December 1992 he postponed a decision to allow VA time to develop a legislative proposal for eligibility reform. In April 1993, the Assistant Secretary for Policy and Planning informed us that work on the eligibility reform proposal was being "put on hold" pending the completion of work by the White House Task Force on Health Care Reform.

Because of our finding that VHA has not complied with the authorizing eligibility legislation in Public Law 100-322, we have continued to report this recommendation as: (1) unresolved in our Semiannual Reports to Congress, and (2) a major noncompliance with law in our annual reports of audit of VA's Consolidated Financial Statement.

Conclusion

In summary, we have identified problems with VA's outpatient workload reporting systems which contribute to resources being inequitably distributed among VA medical centers. We have found that, when resources are not distributed according to consistently reported workload data based on

statutory definitions of eligibility criteria and priorities, some medical centers are forced to restrict access more than others. Because the outpatient eligibility criteria for nonservice-connected conditions are vague and poorly defined, local physicians and other clinical and administrative staff apply the rules according to their own interpretations. While we have made recommendations to improve the reporting systems, access to VA health care will very likely continue to vary widely, depending on which VA medical center receives the veteran's application, unless the eligibility criteria are either changed through legislation or clearly defined by VA policy and regulation.

In addition, I believe that this issue is a symptom of a larger problem relating to how VA plans for and allocates its resources. In my opinion, the lack of performance-based budgeting and reporting within VA, as well as the absence of staffing guidelines, perpetuates the inequitable access to VA health care of similarly circumstanced veterans living in different areas of the country. Work by my office in these areas is underway or planned, and I expect that we will be reporting our findings to VA's top management officials by the end of Fiscal Year 1994. I believe these efforts will identify opportunities for VA to make substantial improvements in distributing its resources more effectively and in ensuring uniform access to its health care services.

HEARING STATEMENT
on
VETERAN ACCESS TO VA OUTPATIENT HEALTH CARE AND RELATED ISSUES

RODNEY R. ZEITLER, M.D.
ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE
VAMC, IOWA CITY, IOWA

JULY 21, 1993

I am pleased to have the opportunity to address this Subcommittee on veterans access to health care.

To provide the Subcommittee a perspective on what has occurred at the VA Medical Center (VAMC), Iowa City, Iowa, I will recount the events as they relate to this issue. In 1989, the medical center was faced with a severe budgetary deficit of $2.9 million dollars. Because of inadequate resources, and/or resource distribution constraints, we were unable to take care of all our existing patients. As a result, a decision was made to decrease 1) the number of outpatients cared for, 2) the non-urgent Category C admissions, and 3) the census in the Community Nursing Home program, so that workload was in closer alignment with the funding available.

At the same time, the Department of Veterans Affairs established an objective of regional equity of access to care. This was driven by the need to constrain total workloads to available levels of funding while striving for regional equity of access. Thus, we were allowed to provide only 1.5 percent of our total inpatient workload to discretionary inpatients and 8.3 percent of our total outpatient workload to discretionary outpatients. Each medical center's situation was a little different which resulted in patients not having equity of access throughout the VA system as a whole.

I will address only the reduction of care to outpatients. The process utilized to reduce the outpatients cared for was as follows:

- The medical records of patients with an appointment of greater than six months were reviewed by registered nurses to determine if the condition for which they were being followed was "chronic and stable." Chronic and stable was defined as having no change in medication or treatment for a 90-day period. The review process began with the lowest priority veteran, Category C, and continued through Category A, Group IV veterans. If there was any question as to whether the condition was chronic and stable, the relevant physician was consulted.

- Once patients were identified as being chronic and stable,

their names were forwarded to Pharmacy Service. If the patient was receiving medications from the clinic for which they were being discharged, a 30-day supply was forwarded to them in addition to a notice of what clinics they were being discharged from and what clinics for which they were still eligible. There were exceptions made for some patients.

This process affected approximately 10 percent of the approximate 15,000 outpatients followed at the Iowa City VAMC.

This reduction or rationing of care had a significant effect on the morale of the clinical staff. The staff were confused by this approach to budget deficit reduction. They resented having patients who we had been most successful in treatment, those with stable medical conditions, being discharged. Success was rewarded with discharge from care.

A large percentage of those patients had no health care provider in the community or could not afford community care. This was in part due to their long-time reliance on the VA for medical care. The patients had allowed their health insurance to lapse or could no longer obtain insurance even if they could afford it. These patients were placed in a very difficult position of having a chronic, although stable, medical condition and limited options for care.

Because of our concern about where these patients would find an alternate source of care, we conducted a study in conjunction with our Health Services Research and Development Service. In June of 1989, a mailed questionnaire was sent to each of the 1,968 patients who had been affected thus far. The study found that one third of the respondents reported that their health status had declined. Twenty-five percent reported that they had not sought follow-up care and 54 percent were not taking all of their previously prescribed medications. This study, Shifting the Financial Burden: The VA Ambulatory Care Discharge Policy, was later published in Health Services Management Research.

I understand that resources are limited. I am well aware of our finite clinic space and staff. I know the costs of medications, diagnostic studies, and other treatments. I would welcome an eligibility reform proposal for ambulatory care that would allow us to be more consistent with the amount of resources we are allocated. In closing, I would remind you that the most vulnerable patients in our system are the low income or Category A veteran. If we do not provide their care, who can or will?

COMMENTS OF DAVID K. LEE, M.D., ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, BOISE VETERANS AFFAIRS MEDICAL CENTER ON:

ISSUES REGARDING VETERAN ACCESS TO VA OUTPATIENT HEALTH CARE.

MR. CHAIRMAN AND SUBCOMMITTEE MEMBERS:

I am very grateful for the opportunity to address an issue of great and growing importance to the Department of Veterans Affairs health care system, and to the well-being of the veteran patients that we serve. In my nearly 15 year career with the Department of Veterans Affairs, the complex eligibility rules governing access to ongoing outpatient care has been a significant issue. I have been Associate Chief of Staff for Ambulatory Care at two Veterans Affairs Medical Centers (Dallas, 1978-1984, and Boise, 1984-present), chair the Western Region's planning board, and am the immediate past president of the National Association of Veterans Affairs Physician Ambulatory Managers (NAVAPAM). In all those roles, the issues of access to care and discharge from care have been major concerns. I would like to address the issues regarding eligibility rules, and the access to care that they govern, from the national, regional, and local levels. I will conclude with concerns about consequences for the patients and the system that derive from widely differing practices regarding access to outpatient services.

NATIONAL. The NAVAPAM membership was sufficiently concerned about inequity of access and barriers to health care that they selected eligibility reform as the subject of a position paper in 1992. When solutions are found to the problems of uneven access, they will be found in eligibility reform, resources, and management of resource distribution. The NAVAPAM paper notes the historical development of present day eligibility. In the years immediately after World War II, most significant health care took place in hospitals. Through the years, the locus of care has changed dramatically. Now, most care is delivered to outpatients, and there are increasing calls for more primary care, with significant elements of preventive health care. Veterans with disabilities related to their period of military service have always had access to outpatient care, either for their service related disabilities, or, if the combination of disability exceeds a certain threshold, for reasonably comprehensive care. Other veterans ability to access outpatient services was tied to inpatient hospitalization, with care usually being provided after an inpatient episode. Public Law 93-82, passed in 1973, allowed provision of care to "obviate" the need for hospitalization. "Obviate" can be broadly interpreted, and individual interpretations have led to the vast disparity of practices characterized in the General Accounting Office Report (GAO-HRD-93-106). NAVAPAM members note practices ranging from ready acceptance of all veterans, including those with income and without service-related disabilities (Category C non-service connected) to the other extreme of acceptance of those absolutely mandated for care (usually with a service-related disability rating of 50% or greater). Two large factors have made this an area of increasing importance: 1. As previously mentioned, ambulatory care has become a much larger part of health care. Not only is more care delivered in the outpatient arena, but evidence is mounting that primary care, with major outpatient and preventive components, is higher quality care. Practitioners in facilities that are "rationing" care, based on a strict interpretation of "obviate", are thus not delivering state of the art care with best possible outcomes, unless the veterans can access other sources of care. This point is addressed by the second General Accounting Office report (GAO/HRD-93-123), and I will return to it later. 2. Society is increasingly mobile, and veterans are moving around the country. It is jarring to discover one has left a source of good primary care only to be denied care in another locality. One of my female patients in Boise moved back to Idaho from the South just to receive care!

REGIONAL. The Western Region Planning Board has noted many of the same issues. Planning initiatives have focused on increasing outpatient clinic capacity and access. A model conference was held in Los Angeles in 1987, resulting in a broad regional effort to

improve ambulatory care and education. While the Western Region has historically had a relatively high level of outpatient activity, the issues of heterogeneity of access have been problematic to the Planning Board. An anonymous survey has recently been completed. Preliminary data reflect barriers to care that differ, reflecting the national trends. Specific medical services are also frequently "rationed", depending on a complex set of factors. Large facilities with in house ophthalmology capabilities had waiting times for elective cataract surgery that ranged from 2 days to 276 days, with a wide scatter in between. Smaller facilities typically depend on the larger ones for referral support. The wide variability probably masks that the same facilities differ in terms of who can receive cataract surgery at all. Our planning efforts will work to reduce some of the variability.

LOCAL. My local experiences have mirrored the national problems. At Boise, we at one time had a very high market share of eligible veterans with a substantial percentage of Category C non-service connected veterans (those with some income). As resources available for care diminished, we had to discharge the Category C patients on our rolls. This, of course, resulted in the rupture of many personal and professional therapeutic relationships. We then formed a highly successful primary care team delivery model, that has markedly increased the satisfaction of both patients and providers. Unfortunately, as the numbers grew to replace the Category C patients that had been discharged, we again lacked the resources to continue care provision. As a result, any new patients that are not absolutely mandatory workload receive only emergency services. We have established a waiting list of these patients, which presently numbers approximately 1,200. (About 7,500 are in the primary care clinics). The patients who cannot be seen are naturally disappointed, especially if they know compatriots in the very successful primary care team clinics. Doctors and physician extenders are also dissatisfied with a role requiring them to be the "bearer of bad news." The system operates to allow a medical evaluation before a determination of eligibility or disposition is made. This is as it should be, because to do otherwise would risk failing to provide needed life-saving emergent care. However, that leaves a clinician, who is trained to provide health care services and ethically to act as an advocate for the patient, in the final position of telling the patient that they need non-emergent services, but cannot get them at this facility.

I have previously mentioned the case of a patient of mine who had back and leg problems. These got worse after she moved to a Southeastern state to the point where this young lady was losing function in her legs. Despite the relatively serious nature of this problem, she was not able to obtain needed services. In desperation, she moved back to Idaho to obtain neurosurgical consultation and resume her care here.

Another exemplary case moved to Idaho from Montana. In Montana, he was receiving ongoing care desperately needed for chronic lung disease, with one lung surgically removed 15 years ago, and now necessitating home oxygen. He also had carcinoma of the prostate, coronary heart disease with congestive heart failure, and a history of gastrointestinal bleeding. When he presented to our facility, chronically ill but without emergent needs, he was advised of our current policy. He indicated his displeasure and that he might have to move back to Montana. To make matters worse, he was from a small town in rural Idaho, and no physician there would take patients for Medicare reimbursement only, which is all he could afford. He was on five different, moderately expensive medications. He appealed his case to members of Idaho's Congressional delegation, and, given the circumstances, we did make an exception for him.

CONSEQUENCES FOR THE SYSTEM. Health care reform will have many components, and its final form is as yet uncertain. Critical elements will include the need to restore the balance between primary care and specialty care. Primary care is often listed as having six key attributes: accessibility, acceptability, accountability, comprehensiveness, coordination and continuity. The highly varied

practices regarding access and eligibility that currently exist diminish many of those attributes. This leads to patient dissatisfaction and provider dissatisfaction. In that Veterans Affairs Medical Centers are also often teaching hospitals, selective denial of access, continuity, and selected services also detracts from our ability to serve as a training arena for primary care practitioners of the future that are so badly needed.

CONSEQUENCES FOR THE VETERANS. Judging by the concerns expressed by Idaho veterans alone, the practices mentioned clearly are associated with significant levels of client dissatisfaction. The accompanying GAO report (GAO/HRD-93-123) addressed the ability of 198 veterans from 6 medical centers to receive care from alternative sources. While 85% were successful in eventually receiving care, 60% of the veterans in question had incomes in excess of $20,000 annually. By now, many VA medical centers are turning away patients with much lower incomes. In Idaho, with the lowest ratio of physicians to population in the United States, there are often few or no alternatives to care for indigent veterans. A study done at the Seattle VA Medical Center, and published in 1988 followed 157 patients discharged from care for budgetary/administrative reasons. Of the discharged patients, seventeen months after discharge 23% had seen no health care provider, 58% believed they lacked access to needed care, and 41% of the hypertensive patients no longer had controlled blood pressures. There were 5.7 deaths per 100 patient months of followup in the discharged group compared to 3.5 in a comparison group that was not discharged. (Fihn and Wicher, Journal of General Internal Medicine, July/August 1988). Consideration of access and care issues must bear in mind the possibility of adverse health status outcomes for the veterans themselves.

CONCLUSIONS.

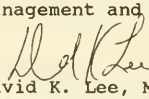
1. Current eligibility regulations are very complicated and difficult to understand.

2. They are unevenly applied across the United States in terms of access to any care at all, or to specific services.

3. This causes dissatisfaction among veterans and VA health care providers.

4. Current restrictions diminish the ability to delivery primary care, which diminishes Veterans Affairs facilities as arenas for primary care training, and may diminish the effectiveness and cost-effectiveness of care delivery.

5. Solutions may require elements of eligibility reform, resource management and additional resources.



David K. Lee, M.D.
Boise Veterans Affairs Medical Center

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JULY 21, 1993

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to communicate its views on the subject of veterans' access to VA outpatient care. This hearing provides an excellent occasion to identify certain concerns with regard to VA medical care resource constraints and the impact of fragmented eligibility rules on quality-of-care and access-to-care issues.

Mr. Chairman, it is time to get to work and be serious about improving veterans' access to VA outpatient care. In our opinion, it is important to document the ongoing problems and concerns of veterans with regard to the denial and fragmented provision of VA medical care. The fundamental problems are known, and various recommendations have been made to improve the relationship between inpatient and outpatient treatment. The issue before us centers on the development of a medical treatment model which allows for a maximum number of patients to be treated at the most appropriate clinical level. VA must develop an equitable and fair treatment policy so that veterans will clearly know what medical services they are eligible to receive. In turn, VA would be better able to plan for and manage its workload by identifying its patient population. The current method of scheduled and walk-in outpatient treatment creates an unmanageable situation. Development of a medically effective outpatient treatment model which focuses on preventive care and continuity of care, and stresses a "holistic" treatment concept is essential. Anything less will continue to perpetuate the ill-conceived system we are here to discuss.

Mr. Chairman, it is essential that this Subcommittee fully understands what problems are interfering with the

successful implementation of VA's outpatient program before it can craft an effective remedy. In our view, first and foremost is the issue of resource constraint and the resulting impact on access to care. The majority of the barriers of access to outpatient care are a direct result of consistently underfunded VA budgets. Secondly, VA is still an inpatient driven health care system. That is, until an eligibility system , along with an appropriate funding mechanism is fashioned to treat more medical/surgical and psychiatric conditions on an outpatient basis, VA has no incentive to follow the private sector model.

Examples of general restrictions on access to outpatient care are numerous. Prosthetics devices can be provided to inpatients but discretionary care veterans may not be eligible on an outpatient basis. Chronic hypertension can be treated on an inpatient basis for discretionary care veterans but not on an outpatient basis. In other words, a chronic hypertensive discretionary care veteran can be treated in VA after they suffer a stroke but not through a preventive care program before hand. Outpatient psychiatric care is mostly limited to service-connected veterans. A discretionary psychiatric patient will be treated if hospitalization is required, but will not be treated to obviate the need for admission, unless it is an emergent condition. Outpatient psychiatric patients are mainly treated in group settings rather than individually as a cost-containment measure. The bottom-line is that current eligibility rules were not designed in the best interest of the veteran, but rather were crafted as ineffective cost-savings measures.

VA is making an effort to transition from an inpatient care model to a more progressive outpatient care model, but still has a long way to go. We believe there is some potential to shift existing resources from inpatient to outpatient care provided changes in eligibility occur.

There will be other costs involved as this transition occurs as facilities will have to ease overcrowded ambulatory care conditions and develop new programs such as ambulatory surgery and day surgery. Additional satellite outpatient facilities, focusing on the provision of primary care services, in lieu of ambulatory care additions, in our opinion, merit consideration.

Some specific examples of outpatient care restrictions have been obtained by Legion field representatives thru site visits to VA treatment facilities over the past year. These are: **VAMC Boise** during the past year has had to restrict low-income Category A patients from receiving outpatient care due to budgetary limitations; **VAMCs Salt Lake City and Denver** limit psychiatric mental health clinic services to service-connected psychiatric patients; **VAMC American Lake** has imposed restrictions on accepting new patients to the general medicine clinic for budgetary reasons; **VAMCs Phoenix, Prescott and Puerto Rico** all control access-to-outpatient care due to severe overcrowding and underfunding; the **Orlando, Florida** outpatient clinic is staffed for 50,000 outpatient visits, yet in FY 1992, the clinic recorded 103,999 visits and has planned for the same workload for FY 1993. At **VAMC Tampa,** the parking situation is terrible, waiting times for routine appointments are over six weeks, with waiting times of over six months in certain speciality clinics. This situation exists despite severe restrictions on discretionary workloads, heavy "overbooking" of most clinics, and other compensatory measures. The demand for outpatient care far exceeds the supply at VAMC Tampa.

At the **Youngstown, Ohio** outpatient clinic the Chief of Staff recently resigned due to clinical safety issues, caused by overcrowded, understaffed conditions. **VAMC Cheyenne** recently lost its only orthopedist, thereby having to refer patients to VAMC Denver. These

referrals are limited to veterans with 50 percent or greater service-connection for an orthopedic condition. For rural America, the issue of lack of access to VA outpatient services is compounded. Both a lack of resources and distances for traveling to a VAMC make conditions much harder for veterans to obtain needed care. **VAMC Miles City** reported that budgetary restrictions have caused the closure of a 20-bed intermediate care unit and reduction of inpatient admissions and outpatient treatment to some Category A veterans only.

Mr. Chairman, a lack of preventive care that results in expensive, emergency treatments and hospitalization for conditions that could have been handled earlier on a cheaper outpatient basis makes no sense. Outpatient care for VA patients is fragmented, patch-work and outdated. In response to the eligibility inequities inherent within the present VA medical care system, and due to the injustice of VA's turning away thousands of deserving veterans for fiscal reasons, The American Legion has authored a plan that calls for the revamping of present VA medical care eligibility criteria. An American Legion Proposal to Improve Veterans Health Care addresses several elements vital to the successful revision of VA health care eligibility reform. We believe that foremost to achieving necessary eligibility reform, sufficient resources must be committed to the plan by the Congress or we will fail.

The American Legion believes there should be only two classifications of veterans: those that are service-connected and those that are not service-connected. Veterans with 0% to 100% service connection should be treated in VA for any sickness or disability. Once access has been gained into the VA health care system, a full spectrum of health care must be available to those veterans. Simply put, those eligibility rules would separate the veteran population into two classifications: those **entitled** to and **eligible** for

care in VA. Funding for the treatment of those entitled to care would come from appropriated dollars. The care for eligible nonservice-connected veterans would be primarily financed through third-party payments, both public and private.

Mr. Chairman, soon the President's Health Reform Plan will be unveiled before the American public. We anticipate that certain recommendations concerning the future role of VA in providing veterans' health care will be proposed. The need to develop an equitable and medically comprehensive eligibility reform proposal for the VA health care system has been recognized for some time, but has progressed at a slow pace. Hopefully, this effort will accelerate in anticipation of the unveiling of the President's Health Reform Plan. The American Legion recognizes the urgent need for this task and will work with the Congress is drafting an acceptable eligibility reform plan.

In addition to simplifying and reforming eligibility criteria, we believe VA should develop a rural veterans health care policy. Veterans in rural areas often spend long hours enroute to obtain care at VA medical facilities. Without adequate transportation systems, veterans, particularly those in their senior years, are forced to negotiate undesirable circumstances, or faced with the alternative, often choose against availing themselves of care. As missions of certain VA medical centers have changed and will continue to undergo clinical realignment, a task force must be established to develop a comprehensive rural health care policy.

The American Legion views the subject of eligibility reform and the completion of VA's National Health Care Plan as top priorities. We hope that substantial progress will be made with regard to these matters prior to or in conjunction with the identification of the VA's role in

national health care reform as identified by the President's Health Care Reform Plan.

Mr. Chairman, that concludes our statement.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
JULY 21, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, may I say we appreciate the opportunity to offer our thoughts regarding the issue of veterans' access to Department of Veterans Affairs (VA) outpatient care services.

Mr. Chairman, I would suggest to you that the manner in which the Veterans Health Administration (VHA) provides outpatient care is, in large part, inadequate to meet veterans' medical needs and their demand for services.

The current manner in which care is provided is inadequate, fragmented, inconsistent and not necessarily geared to what is best for the veteran from a clinical viewpoint, but, rather what is necessary from an administrative and budgetary focus.

Mr. Chairman, there are, in our view, two major compelling reasons the VA's outpatient care structure is unable to meet veterans' needs:

1. Lack of clear, consistent and meaningful eligibility criteria; and

2. Consistent, inadequate funding of the VA health care system.

Although we are indeed appreciative of your efforts, Mr. Chairman, in examining various VA health care issues, we cannot help but feel a certain degree of frustration in continuously witnessing disabled veterans failed attempts to secure adequate VA health care.

My point, Mr. Chairman, is the pressing need to move forward with efforts to create reform of the VA health care system. Understanding the forces at play in the broader picture of reform of the country's health care system, we are, nevertheless, convinced the VA cannot afford to wait much longer before turning to itself for reform.

Mr. Chairman, the VA system has been scrutinized. Your Subcommittee, the Subcommittee on Hospitals and Health Care, as well as the Senate Veterans Affairs Committee have all held a number of oversight hearings; many of the veterans' service organizations have specific proposals for reform and they are remarkably similar in content, if not identical in many respects.

The VA has looked at itself. The Mission Commission has studied VA and offered cogent recommendations for change. VA has studied those recommendations. VA has itself offered meaningful proposals for reform.

Mr. Chairman, we do not believe, as apparently others do, that movement on VA health care reform needs to wait for the First Lady's Task Force recommendations to be made public sometime later this year.

Rather, we believe efforts can now move forward to start VA on the road to reform. The data is available, seemingly the interested and involved parties stand ready to move forward. We are hopeful that a legislative proposal for reform will be forthcoming in the very near future and we genuinely believe that such a bill could receive favorable action during this session of Congress.

Perhaps no area of VA health care now deserves greater attention than that of outpatient care. The current eligibility criteria for the furnishing of outpatient care is found in Section 1712(a) Title 38, USC which provides, outpatient care shall be furnished to any veteran for:

* a service-connected disability;

* any disability of a veteran rated 50 percent or greater for a service-connected disability(ies); and

* a disability for which the veteran is entitled to benefits under Section 1151, Title 38, USC.

Additionally, in order to prepare a veteran for hospital admission or to obviate the need for hospitalization, the VA shall furnish outpatient care to:

* any veteran with a service-connected disability rated 30 or 40 percent; and

* any veteran, eligible for hospital care under Section 1710(a), Title 38, USC, whose annual income does not exceed the maximum annual rate of pension with aid and attendance allowance.

Also, Mr. Chairman, VA is authorized, and may furnish outpatient services to:

* any veteran who is a former Prisoner of War;

* any veteran of the Mexican Border period or of World War I; and

* any veteran who was in receipt of, or entitled to receive, increased compensation or pension benefits based on the need for regular aid and attendance or being permanently housebound.

Finally, VA may furnish outpatient services to obviate the need for hospitalization or for preparation for hospital admission to veterans entitled to hospital care -- "Category A" veterans -- and not otherwise eligible for outpatient care.

Mr. Chairman, VA regulation, in CFR 17.60g, assigns priorities of care for veterans in need of outpatient medical services in the following order.

To any veteran:

* for a service-connected disability;

* with a service-connected disability rated at 50 percent or more;

* with a disability rated as service-connected, including any veteran being examined to determine the existence of a service-connected disability;

* former Prisoners of War;

* eligible for treatment for conditions which may have resulted from exposure to dioxin or ionizing radiation;

* who is in receipt of pension;

* unable to defray the expenses of necessary care;

* nonservice-connected veteran agreeing to make copayments for such care.

Mr. Chairman, it is our belief that VA medical facilities across the country when faced with such a complex, confusing, and ambiguous set of eligibility criteria, compounded by a systemic lack of resources, often make decisions that lead to a denial of care or, more commonly perhaps, a rationing of care. Currently, this scenario adversely affects a veteran's ability to receive adequate and timely health care services.

It is without argument, in our view, that VHA is caught in at least a decade long -- more likely longer -- funding crisis. As pointed out in the Independent Budget, VA spending in constant dollars has been declining while national health care expenditures have increased dramatically. In Fiscal Year (FY) 1980, VA funding amounted to 4 percent of the federal budget; by FY 1990 it was only 2 percent. In FY 1985, VA received 7.7 percent of federal health care dollars; in FY 1995, VA may expect to receive only 4.4 percent. Also, because health care inflation has outstripped general inflation, and because the Office of Management and Budget, under past Administrations has consistently underestimated inflation, funding for VA has steadily eroded VA's purchasing power.

As in past years, the authors of the Independent Budget conducted a representative sampling of VA Medical Centers via a telephone survey. The surveyed facilities ranged in size, mission and location. Facilities acknowledged the chronic budget shortfalls plaguing their facilities. The majority of facilities surveyed reported budget shortfalls ranging from $1 million to $5 million during FY 1992 with expected similar shortages in the current Fiscal Year. The current survey revealed one significant change in that almost all those surveyed admitted to an increasing ability to adjust to budget shortfalls. The most common method used to accommodate the budget shortfalls was the delay in plant maintenance and equipment replacement, rationing of medical care and staff reductions.

Mr. Chairman, as one who reads letters from veterans and talks to veterans on the telephone on a daily basis, I feel somewhat qualified to relate, albeit in general terms, the plight of many veterans seeking VA health care services on an outpatient basis.

Without question, and as previously mentioned, the greatest impediment results from the current eligibility criteria. Veterans who are readily admitted for a period of inpatient hospitalization and treatment often encounter frustrations when attempting to secure physician ordered follow-up outpatient care. Such rationing of care leads to inadequate clinical follow-up from a period of hospitalization which often calls into question the adequacy of the care received.

We find many outpatient clinics have backlogs for appointments with some clinics having a six month or longer waiting period. Also, follow-up clinic visits are sometimes scheduled much longer than is judged medically proper, i.e. rather than returning to the clinic in one month, the appointment may be made three months later. These backlogs and

prolonged waits between clinic visits are almost always the result of inadequate resources, both dollars and staff.

We have encountered numerous instances where certain clinics have been closed to certain categories of veterans and clinics not accepting new patients. Many clinics are restricted only to the highest priority veteran, or only those with service-connected disabilities. Also, we have discovered some mental health clinics creating additional restrictions that only service-connected veterans possessing a certain degree of disability are able to be seen.

A common complaint voiced by veterans is that "block scheduling" occurs. Such scheduling occurs when a large number of veterans are scheduled at the same time on the same day to see the same doctor. With block scheduling, many veterans relate intolerable waiting periods of six, seven, or more hours in order to see a physician for care.

Another impediment to the provision of adequate outpatient care services is the fact that many facilities lack adequate clinical space. Compounding the problem is a lack of construction dollars in order to initiate renovation projects. In our view, the VA has been slow in moving toward ambulatory surgery rather than the more costly process of admitting patients for surgical procedures that could be accomplished on an outpatient basis.

Mr. Chairman, veterans have voiced their sentiments that the intolerably long waiting times experienced in attempting to access VA care has led them to simply give up on the system. When this happens, many eligible veterans consciously avoid seeking further assistance from the VA and, as a result, many times go without needed medical care services. Clearly, this is an intolerable situation.

An area of long-standing and great concern to the DAV has been that of rural veterans being unable to avail themselves of VA health care services. Although this has been and remains a vexing problem, we are somewhat encouraged by the VA's moving into an era of utilizing mobile health care clinics to reach out to such veterans. We feel there is a definite place in the VA health care system for such mobile clinics and encourage their continued use and expansion.

A final area that deserves to be mentioned, Mr. Chairman, concerns VA policy of providing fee-basis care. As you know, veterans may be authorized to participate in VA's fee-basis program when it is determined a veteran is, for various reasons, unable to utilize a VA medical facility. Such reasons include the non-availability of the required treatment by the VA or the veteran's geographic proximity to VA.

An often voiced complaint is that VA arbitrarily cancels veteran fee-basis authorization without adequate reason or explanation. VA needs to monitor this program to ensure veterans receive the care they are eligible for in a quality and timely manner. Veterans medical care should not be compromised for the sole reason of financial incentives for the local VA medical facility.

In the same vein, Mr. Chairman, the VA must make concerted efforts to establish a VA presence where there is a documented need. Small, satellite or community-based clinics provide eased access into the system. Often times such clinics are able to meet veterans needs by providing the most basic of health care services and screening mechanisms that in the long term may alleviate the need for more intense intervention based on a progressive worsening of the veteran's condition.

We believe, Mr. Chairman, there currently exists a structure in which to greatly expand the VA's presence in the community. We are referring to Vet Centers.

Mr. Chairman, we believe that with some creativity and cooperation between the Vet Centers and nearby VA medical centers, a partnership can be developed wherein health care professionals, i.e. physicians, nurses, physicians' assistants, dieticians, etc., can spend some time in the Vet Center providing basic health care services to eligible veterans. We understand certain legislative authorities would have to occur in order for this to happen, however, we believe with such authority and a small shifting of resources, the VA will be much better positioned to provide the kinds of services that veterans require in a setting that is readily accessible.

Mr. Chairman, we believe that with some commitment and motivation together with statutory relief, the VA is certainly capable of rectifying the situation we now witness concerning outpatient care services. Specifically, we refer to the issue of eligibility reform and the need for a clarification of who is eligible for care and the scope of services included in that care. Once this is accomplished, we believe the VA must make a concerted effort to break away from the traditional bed-based system they have always been and move more in the direction of focused ambulatory care. This makes sense from both a clinical and economic basis.

To the VA's credit, Mr. Chairman, it is our impression that many VA facilities have instituted a primary care program as their preferred method of delivering outpatient care services. As we understand it, this entails the veteran being seen by the same physician each time they visit the clinic. In this scenario, the physician is able to become the case manager of the veteran's care. The obvious result is a higher quality of care delivered to the veteran. We encourage and urge VA to expand in this and other types of innovative care programs. To do so only benefits those who VA is mandated to serve, the disabled veteran.

Mr. Chairman, this concludes my statement. I will be pleased to respond to any questions you or the Subcommittee members may have.

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

REGARDING

THE PROVISION OF OUTPATIENT SERVICES AT VA MEDICAL FACILITIES

JULY 21, 1993

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the status of outpatient services provided in the Department of Veterans Affairs (VA) medical facilities and the pressing need to clarify eligibility for those services to assure the provision of a full continuum of care for all VA patients. Providing a comprehensive package of health care benefits takes on even greater urgency as the Administration and the Congress prepare to reform the nation's health care system with VA as a full participating partner.

At the present time, health care sponsored by VA is an inconsistent patchwork of services ruled by an incoherent system of eligibility criteria. Nowhere can these inconsistencies be more clearly seen than in the provision of outpatient services. For example:

> Veterans with service-connected disabilities rated 50 percent or more have unlimited entitlement for inpatient and outpatient services.
>
> Other service-connected veterans rated below 50 percent are eligible for outpatient care, but only for their service-connected disabilities. These veterans seeking services for the balance of their care along with the low income Category A nonservice-connected veteran and the "special category" veterans (World War I, Agent Orange etc.) can only receive outpatient care on a space available basis or by individual determination to obviate the need for inpatient treatment, or as a follow-up to hospitalization.

These fractured eligibility criteria prevent the provision of appropriate, cost-effective treatment for the vast majority of veterans seeking care from VA. They also counter current trends in modern medicine that place increasing emphasis on primary care, prevention and outpatient services. No amount of management reform, restructuring, or realignment of the VA system can free VA health care professionals and their patients of the constant

question mark of eligibility without overcoming this fundamental impediment.

Coupled with funding shortfalls that have plagued VA for the past decade, the eligibility uncertainty fosters a scenario that breeds arbitrary medical selection of patients and services as well as inconsistency of treatment between regions and facilities within VA. The system - or actually the lack of a coherent eligibility system - leads to inappropriate rationing, delays and outright denial of needed care. It also greatly increases the cost of services forcing VA health-care professionals to warehouse patients in expensive inpatient settings when ambulatory care or other alternatives would be far more appropriate and cost-efficient.

It is no wonder that the Subcommittee has identified numerous instances where veterans have been denied care or delayed treatment as a direct result of funding shortfalls and compliant eligibility criteria that make certain types of treatment for certain categories of veterans in certain VA medical centers wholly discretionary. Such a situation is bad health policy and bad medicine.

PVA has urged the Congress for years to correct this imbalance; so has every major veterans' organization, the "Independent Budget", the VA's own, "Mission" Commission on the Future Structure of Veterans Health Care and the General Accounting Office (GAO). PVA's initial review of VA's role in a reformed national health care system, "Strategy 2000, The VA Responsibility in Tomorrow's National Health Care System," made standardizing eligibility one of its top priorities.

The VA, over the past year, launched an initiative to come forward with a definitive legislative proposal to clarify eligibility for all VA services for all eligible veterans - outpatient, inpatient and long term care. PVA was disappointed when that initiative was placed on hold earlier this year. We understood the political rationale as well as the promise that the delay was only temporary and that the problem would be solved in the context of the Administration's health care reform plan. However, the delays in the Administration's Health Care Reform proposal have been frustrating and to a certain extent disconcerting on this point. Another year will have passed leaving this problem of eligibility still unresolved. Correcting what has become a chronic problem for the VA system could have a potentially unsatisfactory solution if it becomes entangled in the protracted debate over reforming the nation's health care system in the months ahead.

We have received strong assurances from the President, the First Lady and the Secretary of Veterans Affairs that the Administration's health care reform proposal will include VA as a viable independent health care system. We are truly grateful for their support and the major role VA has been allowed to play in the President's Health Care Reform Task Force. However, the question of eligibility and the ability of VA to market its services will be the ultimate test of exactly how independent VA will be in the competition for services among providers of all sizes and shapes within the Administration's plan.

VA has a critical role to play in the provision of health care for veterans. From that standpoint it should have a distinct and unique set of health care benefits that are tailored to attract veterans to come to the VA and remain with the system for their care. Among those services are outpatient care and certainly comprehensive long term care for all eligible veterans. In PVA's opinion there can be no future role for a VA health care system without the inclusion of a comprehensive long term care benefit to meet the needs of the aging veteran population.

VA health care benefits should be compatible with a reformed national health care system. But the design of the health benefit package should recognize the fact that VA starts out at a distinct disadvantage with other providers within a Managed Competition setting.

To compensate for this disadvantage, VA should be able to:

Define who is eligible to receive VA services. The core group of eligible veterans should consist of: service-connected disabled veterans, low income veterans and special category veterans. In addition, the core group should include veterans who become "catastrophically disabled." Catastrophically disabled veterans will eventually fall under the umbrella of one or another federal programs, currently Medicare or Medicaid. They should have a choice to seek services, particularly specialized services, such as treatment for spinal cord injury through the veterans' health care system as well. Health care for core group veterans should be financed through mandatory appropriations.

Offer a comprehensive benefit package that provides for a full continuum of care - inpatient, outpatient, non-institutional and institutional and long term care.

Offer identical benefits to non "core group" veterans willing to pay co-payments and deductibles to enroll in the VA system.

Collect and hold third-party payments from public and private insurers for all nonservice-connected care to help underwrite the cost of running the system.

Expansion of eligibility for the full continuum of care including comprehensive outpatient services need not "break the bank." While VA has greatly reduced its lengths of stay over the past decade, it still retains a bias to over-utilize expensive inpatient care where other forms of treatment would be more appropriate. Part of the reason for this is brought about by the physical structure of the VA system which has always placed greater emphasis on inpatient services, minimizing outpatient access. The other, greater cause is the lack of clear eligibility for outpatient services which would force VA to be more responsive to expand its outpatient capability. Recent studies by VA health services' researchers found that in several VA medical centers up to 40 percent of hospital admissions reviewed were inappropriate. PVA has done similar reviews using VA's patient treatment file finding that a substantial number of inpatient care episodes, particularly one and two day stays, were for services that could have been performed more appropriately on an ambulatory basis.

Adjusting to full eligibility for outpatient care, VA will have to expand its current ambulatory capacity at medical centers and establish a broader network of satellite clinics and community-based primary care operations. A rational realignment of appropriate treatment coupled with eligibility reform could shift millions of dollars from unnecessary, non-acute hospital days to more appropriate and economical ambulatory care. The shift would provide more appropriate care at lower cost to current users of the system and cover the cost of increased system utilization caused by the expansion of eligibility.

Mr. Chairman, the process of reforming the nation's health care system will present great challenges to the Department of Veterans Affairs' health care system. VA will not be able to compete or survive in this process unless it is given a substantial and

comprehensive benefit package designed to provide a full continuum of care - including outpatient services and long term care. PVA remains concerned that the opportunity to address comprehensive eligibility reform could be weakened or lost in the process of national health care reform. We urge the members of this Subcommittee and the full House Committee on Veterans' Affairs to maintain a watchful eye to be certain that our goal of providing a standard comprehensive health benefit for all eligible veterans is achieved.

This concludes my statement, Mr. Chairman. I will be happy to respond to any questions you might have.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Paul S. Egan
Executive Director

Before The

House Veterans' Affairs Subcommittee On Oversight and Investigations

On

VA Outpatient Health Care

July 21, 1993

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Introduction

Mr. Chairman and members of the subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on the issue of VA outpatient health care, and was pleased to provide answers to the insightful pre-hearing questions. As the responses to these questions clarify our position on this issue rather well, we have kept this written statement brief.

While there are distinct problems with the current facility-specific eligibility admission standards, there are also broader eligibility reform issues and private sector medical trends the VA will need to conform with to become competitive within a reformed national health system. We commend you for holding this hearing, which is the first step Congress has made to address the desperately important and time sensitive topic of VA health care eligibility reform.

Inconsistent Application of Eligibility Criteria

The current VA eligibility criteria are so convoluted that veterans certainly cannot understand what they are entitled to, and it seems that VA personnel don't comprehend them either. As such VAMC admissions officers don't apply eligibility restrictions equally to all veterans seeking care. If this is allowed to continue, VA cannot hope to become an efficient complement to a national health care system.

VA currently allows each facility to determine which veterans will be treated based upon locally devised rules and locally determined preferences on the use of scarce resources. Different facilities have different eligibility rules for inpatient and outpatient care. Even the same facilities have different eligibility rules for inpatient and outpatient care. In many cases there are eligibility variations depending upon the specific type of treatment sought. How VA expects not only to retain current users of this system, but attract new users as well in a national health environment, without changing its consumer-friendliness image is a genuine mystery.

Faulty Central Office Management

Part of the problem facing the VA is its failure to effectively coordinate management responsibility between the Central Office and local VA facilities. Currently, the sprawling system that is VA health care as we know it consists of 171 hospital and satellite outpatient fiefdoms free to provide or not provide whatever they wish, to whomever they wish, whenever they wish and without effective controls or guidance from VA Central Office. VA Central Office apparently believes it can manage this system by relying upon its regional health bureaucracy.

A more appropriate division of responsibility would give Central Office managers the authority to mandate the minimum services and minimum mix of services to be provided in both VA medical centers and outpatient clinics. Certainly, local facility managers are in the best position to determine the needs of the local VA-dependent population of veterans. These managers should submit to Central Office their proposals for meeting the needs of local VA-dependent populations so that local conditions can be appropriately weighed by Central Office when resource allocation decisions are made. Moreover, VA Central Office must be in a position to assure itself that what the field is asking for is indeed what is needed by veteran users. The importance of appropriately balancing management responsibility between Central Office managers and local facility caregivers takes on added significance with national health on the horizon. Most obviously, this is because the VA intends to hold itself out as a care provider current non-users of the system will find attractive and be willing to subscribe to, instead of private-sector managed care options.

The only way the VA can succeed in efforts to attract current non-users of VA-provided health care, is for Central Office to insist forcefully that local facilities prepare in earnest to meet new and different care demands than they are meeting at the present time. Similarly, VA Central Office must be prepared to guarantee consistency in its eligibility criteria for both inpatient and outpatient care. However

consistent the eligibility criteria, ease of access to inpatient and outpatient care must be equal to that available to subscribers of private-sector managed care providers.

Countless cases come to our attention from the field of veterans who are turned down for outpatient care because the clinics are full, because the physician won't see them, or because the services they need are not provided at that particular VAMC. Sometimes they are given care on one visit, and are turned away from the same services on follow-up visits. Often service-connected and low-income veterans are denied basic services, while the same facility provides more specialized services to all veterans regardless of income. On occasion, a VA physician will admit a veteran as an inpatient in order to provide needed services which the veteran is not entitled to receive on an outpatient basis. If a veteran raises objection to how he or she is being treated, it's as though they lose eligibility because the local VAMC won't treat them any longer. And sometimes eligibility is denied through attrition, when waiting times are so long that veterans simply give up and go home.

Who Should Be Eligible?

Certainly the VA was never designed to be, has never been, and should not attempt to be all things to all veterans. Likewise, it doesn't make any sense for each VAMC to provide all health care services. Doing so would likely be impossible, even if the VA's health budget were tripled.

In order for the VA to avoid an exodus of current VA-dependent users it must seriously evaluate who it can serve most appropriately. Decisions must be made and codified by Congress defining which populations of veterans will be served. Whatever those populations might be, the full continuum of services must be provided either at the VA, through contract providers or using sharing arrangements. From VVA's perspective, the most appropriate populations of veterans to be served are those same populations the VA is currently serving as well or better than the private sector. In order for VA to attract new users to the system, it must be prepared to provide what is usual and customary in the private sector irrespective of eligibility reform.

The bottom line is this--veterans should be able to access health care anywhere in the nation they choose, within the VA health system or elsewhere, at any time. Until this fundamental right to choose a health provider is put in place, the VA will have no incentive to improve its services sufficiently to either retain current users or attract new ones. Certainly ease of access to VA health care on both an inpatient and outpatient basis is one important step toward change that must be made.

Ease of Eligibility is a Factor in Quality

Today veteran users of VA health care are essentially condemned to a system that many cannot easily get to, and would choose not to use if a choice were available. The most important reason a choice to use non-VA health providers would be made is that, rightly or wrongly, veterans perceive the quality of care provided as seriously deficient compared to the private sector. This raises the important question of how quality is defined and by whom. The VA today measures quality according to the preferences of teaching institutions, researchers and bureaucrats. Nowhere is quality as defined by veteran users addressed in any meaningful way. Were it otherwise, the VA would have long ago realized that the eligibility maze to which it subjects VA-dependent users has made the VA decidedly consumer-unfriendly.

Often, the VA defends the quality of its product by comparing its health outcomes with those of private sector facilities. From a consumer's perspective, this is a false measure of quality, because it ignores what happens from the time a patient enters the door of a hospital or outpatient clinic to the time the patient is discharged. Typically, VA patients' perception is that the VA treats patients less professionally, less courteously, more invasively, less comfortably, less conveniently, with less privacy and discreetness and in a less timely manner. As important as these basic consumer-driven indices of quality are, simply getting in the front door of a VA inpatient or outpatient facility has become so daunting and so frustrating that ease

of access through eligibility reform must also be seen as an important component for improving the quality of care provided at VA Medical Centers and outpatient clinics.

The Tail That Wags the VA Dog

VVA has always contended that medical school affiliations are all too often the tail that wags the VA dog. Headline-grabbing horror stories emerge from time to time, such as the recent fiasco at the North Chicago VAMC where unnecessary surgeries were performed by insufficiently supervised students ending in "medical misadventures". Attempts were made by facility managers to cover-up the fact that veterans were systematically being used as lab rats for medical education purposes, whether they needed treatment or not. We receive calls more frequently than you might imagine from veterans who are unable to receive treatment for PTSD--a clearly veteran-related and service-connectable problem--because vacant beds are being held for individuals with mental disabilities seen by the medical school affiliation to be more suitable for training psychiatric interns and residents.

It is evident enough to us that eligibility criteria used by some hospitals more properly respect the preferences of medical schools than the needs of local VA-dependent veterans. Under the circumstances, the ability for VA Central Office to dictate minimum standards of service and mixes of services as discussed above will become critically important in assuring that the VA is the master of its own health provider destiny. As things stand today with local VA health facility managers enjoying excessively broad discretionary authority in defining eligibility, their dependence on medical school students who provide direct inpatient and outpatient care, makes them vulnerable to the preferences of the medical school affiliation.

By this, we mean that in order to maintain the supply of medical students who perform patient care in VA hospitals, each VAMC needs to meet the teaching opportunity needs of the affiliated medical schools. For example, if a particular school has a strong emphasis in dermatology specialization, the VAMC may have a derm clinic whether or not the local Category A veteran population generates sufficient demand for these services. Is it any wonder that we all hear of instances where Category A veterans somehow fail to meet the prescribed eligibility criteria, while others receive care?

VA Central Office needs to establish controls which would prevent undue influence of medical schools and VAMC territorial protectionism in the management of resource allocation. It is the lack of Central Office control and direction that has led to the current haphazard, facility-based eligibility policies which have balkanized the availability of VA health care, often harming the service-disabled and economically disadvantaged veterans the most.

Vital Necessity of Comprehensive Eligibility Reform

VVA has consistently advocated that eligibility reform should be enacted to simplify the myriad of eligibility criteria, and certainly the advent of national health system reform will make this imperative. We believe that veterans will walk away from the VA's complicated eligibility-based admissions, running instead to the easier-to-access national health care system where they can receive the full continuum of care on a medically appropriate inpatient or outpatient basis, and will never return. This will hold true unless VA eligibility reform is enacted from day one of the national health system.

While Secretary Brown has stated that eligibility reform will proceed after the unveiling of the Clinton health plan, we recommend that VA eligibility reform should <u>not</u> wait. Both the Clinton health reform plan and VA eligibility reform could be quite complicated and completion of legislative consideration could be lengthy. There are system-wide adaptations that will require advance preparation to be completely ready for implementation, such as staffing and equipment adjustments, paperwork adaptations, etc. We would recommend passing eligibility reform in advance of the Clinton health package, with the effective date coinciding with implementation of

national health reform. Failing to coordinate these legislative initiatives threatens the ultimate survival of the VA health care system.

Never before was comprehensive eligibility reform fiscally desirable, as the current maze of restrictions have served as the floodgates holding back demand for health care services by veterans who have no other health care options. National health care reform will give these veterans another option, however, and reports by GAO and the Paralyzed Veterans of America (PVA) attest that it is doubtful that large numbers will still wish to use the VA. Open eligibility will be required to sustain sufficient patientload demand on the VA to keep it from becoming a ghost town, and should be tailored to attract those veterans the VA serves best. These populations of veterans are the aging, blind and spinal cord injury patients, veterans needing prosthetics, long-term mental health and PTSD treatment, substance abuse programs, among other suitably selected populations.

Private Sector Medical Trends

There are two tenets of current private sector managed health care that VA needs to focus on, as well, in order to become a consumer-oriented, quality health care provider that can entice veterans with health care options to choose VA. This involves the emphasis on cost-effective outpatient procedures rather than requiring extensive hospital stays for simple procedures; and it includes elements of managed care which incorporate primary and preventive care and specialized care to provide comprehensive treatment and follow-up.

An example we used earlier to demonstrate illogical outpatient eligibility restrictions was that of veterans being admitted as inpatients to receive basic care generally provided on an outpatient basis in the private sector. These occurrences present examples of what we believe are medical school preferences for an inpatient hospital learning experiences, and also raise costs.

The private sector has realized the cost-effectiveness of providing basic procedures in ambulatory clinics, rather than requiring overnight stays. An additional advantage to outpatient care is that veteran patients are able to stay at home with family and familiar surroundings, a technique which has been proven to shorten recovery times.

Secondly, standard, logical business practice and provision of medical care should be mutually consistent even in the government, and dictate that centralized management standards utilize budgeting and resource allocation to make its operation as cost-effective as possible. VA Central Office needs to shift resources to meet demand; produce services in-house where they are most in demand, and purchase services from non-VA providers where economies of scale cannot be established.

Certainly, from a management perspective, this sort of massive coordination is a huge and difficult task to undertake. Isn't this the purpose and advantage, though, of having such an agency as the Veterans Health Administration (VHA)? If this means taking personnel and/or equipment out of a facility where it is underused, to be placed in another where it will be used efficiently, so be it. If this means providing fee-for-service cards to eligible veterans or transferring them to other VA facilities because the specific services they need are not provided locally or the time and space to provide this treatment is not available in the nearest VAMC, so be it.

Mr. Chairman, this concludes our testimony.

PRE-HEARING QUESTIONS
FOR JULY 21, 1993 HEARING

House Veterans' Affairs Subcommittee
on Oversight & Investigations

1. ***Are VA decisions on providing outpatient care inconsistent (a) among and (b) within medical facilities? Should these decisions be more consistent?***

From the information we were able to gather from the field, the general consensus is that a veteran's chance of receiving needed outpatient care from a VA facility on any given visit is rather random. The inherent unfairness in not implementing consistent regulations is obvious. If a veteran is provided with treatment on one visit and is turned away on a subsequent visit for the same treatment, very clear questions about quality of care come to mind. Similarly, when one service-connected patient is turned away and another is provided outpatient care based upon consideration of income, there are distinct concerns about how VA is prioritizing budgets. Finally, when a veteran must be admitted as a hospital inpatient in order to receive needed treatment that is commonly performed as outpatient care in the private sector, it seems that eligibility criteria are skewing the patientload such that costs increase.

2. ***Please discuss VA provision of outpatient care being dependent upon:***
The VA medical facility from which the veteran seeks care.
The type of care or treatment needed by the veteran.
The health care provider or facility representative from whom the veteran seeks care.

According to our field representatives, there is no consistency by which veterans are admitted for treatment among VA Medical Centers in any given region, nor in individual facilities. There are indications that some veterans seeking specific treatments are being turned away by a facility, and even that eligible veterans may or may not receive treatment depending upon whether a physician or specialist will see the veteran. Some veterans are being turned away based upon personality conflicts with the facility eligibility or admissions representative. For instance, if a veteran seeking outpatient care for symptoms of PTSD is treated unprofessionally by the admissions officer and takes the complaint to a higher authority (a logical step in making a consumer complaint), this veteran is branded "a troublemaker" and may be outright denied care. And finally, we note that many VAMC directors have refused to provide care to incarcerated veterans.

3. ***From the perspective of an individual veteran, examine the consequences of inconsistent decisions on provision of outpatient care among VA medical facilities.***

A veteran is obviously going to attempt to access the nearest VA facility first. If turned away here, but given indication that efforts may be more successful at another facility, he or she will be forced to travel potentially long, difficult or costly distances to access care. Some VAMCs will not cross regional boundaries, however, and refuse to treat veterans who rightfully should seek care at the nearest VAMC. For example, one VVA member told of a veteran being denied outpatient care at the Beckley, WV VAMC and subsequently being turned away from the Huntington, WV VAMC, not because Huntington deemed him ineligible, but because he should have gone to the Beckley VAMC. A final verdict was delivered to this veteran that because he was retired from the military he must travel over 200 miles to Lexington, KY to a DOD hospital, even though he was seeking treatment for a service-connected condition. VAMCs try to "dump" patients because it leaves additional budget funds available.

If the veteran is eligible for VA outpatient or inpatient care, eligibility should be granted wherever he or she lives. In effect, these inconsistencies establish geographic discrimination.

4. ***From the perspective of an individual veteran, examine the consequences of inconsistent decisions on provision of outpatient care within VA medical facilities.***

Again, if veterans are eligible for outpatient care, they should be able to receive this care consistently over time. Many medical conditions are ongoing and require a series of physician visits. If a veteran is provided care on one occasion and is denied care on another, the VA facility is not performing its medical obligation to provide follow-up care. In addition, if one veteran is provided care for a specific ailment while another with like eligibility is turned away for the same condition simply because the doctor doesn't feel like seeing the veteran, equal access to quality care is not being served.

5a. ***Should some VA medical facilities ration outpatient care by not providing care to service-connected veterans for nonservice-connected conditions while other facilities serve all high income veterans who request outpatient care?***

No. If some facilities are overburdened such that a priority eligibility group must be turned away while veterans with lesser eligibility are treated at other facilities, resources should be shifted or reallocated so all facilities are providing care to the priority groups before eligibility is opened to nonservice-connected veterans with high incomes. If it is impossible for VA Central Office to manipulate resources from facility

to facility, arrangements must be made to ensure that priority eligibility veterans receive the care they are entitled to and need through contract providers, DOD sharing arrangements or fee-for-service.

b. ***Should some VA medical facilities ration outpatient care by not providing care to low income veterans while other facilities serve all high income veterans who request outpatient care?***

No. Again, resources should be reallocated in order to balance the entire system and consistently provide care to the various priority eligibility groups. And likewise, if it is impossible to provide care for these priority eligibility veterans, arrangements for care provision must be made through contract providers, DOD sharing arrangements or fee-for-service.

c. ***Should some medical services within a VA facility ration outpatient care to service-connected veterans for nonservice-connected conditions or to low income veterans while other medical services in the same facility serve all high income veterans who request care?***

No. If some services, facilities, equipment or personnel in any VA facility are underused such that eligibility is opened to all veterans, while priority eligibility veterans are turned away from other services, resources should be shifted within this facility to ensure continuity. This will be difficult, as some types of very specialized medical equipment or personnel may not be transferable to other clinics. Yet, this is a principle for which the VA facilities and the system as a whole should all strive.

d. ***Is it desirable for a lower income nonservice-connected veteran to be denied needed outpatient care by one VA medical facility and then be provided this same care by another VA medical facility? Please explain your response.***

No. As previously stated, the veteran will try to access care in the proximity to his or her home (or shelter, if the veteran is homeless). Forcing the veteran to travel will place undue financial burden, and perhaps even additional medical strain, on his or her situation. VAMCs sometimes place restraints on services to veterans residing outside the VAMC's territorial domain.

If it is a matter of the veteran seeking specialized care that is unavailable at the original VA site, the facility should arrange and provide transportation to the second VA location. For instance, it is illogical for each facility to have a specialized Spinal Cord Injury unit, and therefore referrals should be made to a regional center. Thus, the veteran is not denied care at the original VA contact site, but a simple patient transfer takes place.

If an eligible veteran chooses to receive specialized care that is not available with the original VAMC through a non-VA provider, the VA should facilitate this and cover these costs.

e. ***Is it desirable for a VA medical facility to initially deny a lower income nonservice-connected veteran needed outpatient care and then subsequently in response to another request for this care from the same veteran provide the needed outpatient care which was previously denied? Please explain your response.***

No. If the veteran is eligible according to national VA regulations and legal mandates, he or she should be provided care. If the facility is unable to provide the care, the veteran should be given fee-for-service with non-VA providers, contract-provider accommodation or should be transferred to another VAMC that can and will provide the care. It is desirable to keep the veteran close to home via the health care provision through fee-for-service or contract-providers, when referral to a specialized regional care unit is not medically required.

f. ***At some VA medical facilities, some higher income veterans have reportedly received outpatient care for certain conditions while lower income veterans did not receive care for other conditions. Please comment on this finding.***

This is probably due to the dilemma discussed in question 5c, in that some highly-specialized clinics may be underused, and thus eligibility for these services is opened to veterans regardless of income. Busier clinics may be forced to turn low-income veterans away because of resource constraints. Attempts should be made to address this, as discussed, by shifting resources.

6. ***Should priorities for VA outpatient care be uniform system-wide or should each medical facility establish facility-specific priorities for providing discretionary outpatient medical care? Please explain your response.***

Certainly. In fact, the ideal situation is that both outpatient and inpatient care criteria should be uniform system-wide, and eligible veterans should be able to receive the full continuum of care.

If a veteran under VA care happens to move to another location at which he or she is not eligible for care according to facility criteria, there is injustice because his or her service record has not changed, nor should eligibility. If a veteran is receiving care while another with comparable eligibility is turned away simply because he or she tries to access a different facility, there is discrimination taking place.

7a. Please discuss the ability of veterans who do not receive all requested or needed outpatient care from VA to obtain these services from non-VA providers. Do all VA medical facilities which do not provide all veterans all needed or requested outpatient care, assist all veterans who are not provided all needed outpatient care to obtain this care from non-VA providers? Is this assistance consistent among VA medical facilities? Is this assistance consistent within VA medical facilities?

While some VAMCs do provide fee-for-service cards for veteran patients, or make arrangements for contract-providers, many technically eligible veterans are still turned away and do not receive assistance in obtaining non-VA care. An example of this may be provision of fee-for-service to a low-income woman veteran because gynecological services are not available at the local VA, while a male veteran is turned away from outpatient care because of overburdened clinics. The VAMC may rescind non-VA and fee-for-service arrangements at any time, however. Perhaps a new wing is built at the hospital to accommodate women veterans' privacy needs, but this doesn't necessarily mean the gynecological health services are available.

In general, veterans seeking medical services at the VA do so because they have no other means of accessing health care. Either they are uninsured or underinsured, their private insurance won't cover service-connected conditions, or the scarcity of health care providers in the region makes VA the closest option. Thus, a veteran turned away from the VA is often unable to get any health care services.

8. When a veteran is not provided all needed outpatient care by VA, does VA monitor or attempt to monitor the results of the veteran's efforts to obtain needed outpatient care from a non-VA provider? Is this monitoring consistent among VA medical facilities? Is this monitoring consistent within VA medical facilities?

No. When referral and the use of contract-providers and fee-for-service are limited, inconsistent or non-existent, there is obviously no monitoring. If in fact this is being done in some VA Medical Centers and we are simply not aware, it cannot be consistent. It is very important that VA Central Office control and direct such monitoring and follow-up to ensure that all VAMCs are providing care to priority eligibility veterans either directly or through non-VA providers.

9. Are outpatient health care rationing decisions consistent among VA facilities? [When all needed outpatient care is not provided by VA, do all VA facilities provide the same partial outpatient care services, consistent with the needs of the veteran?]

No. The classic example of this discrepancy is the varying availability of women's clinics. Some VAMCs have more specialized services available, such as dental clinics, outpatient substance abuse programs, dialysis, etc. Eligible veterans needing those services that are not locally available should have the option of being transferred to another VA facility, or referred to private sector care at the VA's expense. In general, veterans attempting to access care at the VA do so because they have no other means to access care. Being turned away from the VA, for many veterans, means they will not receive needed health care services.

b. Are outpatient health care rationing decisions consistent within VA facilities?

No. Sometimes, the rationing comes into play by making the veteran wait so long for the outpatient physician appointment that he or she gives up and leaves. Other times, a veteran may be turned away while others with similar eligibility seeking the same care a granted appointments. Application of eligibility restrictions appears to be rather random, because criteria are not clear.

10a. Please discuss the consequences of VA medical facilities using different methods to ration outpatient care.
10b. How are veterans affected by VA medical facilities using different methods to ration outpatient care?

Allowing each VAMC to determine its own eligibility criteria in effect creates discrepancies that discriminate against some groups of veterans based upon geography. Naturally, veterans who live at a distance from the nearest VA facility already have more difficulty accessing their health care entitlement. Variations in and among VAMCs in determining eligibility constitute institutionalized discrimination.

11a. Should all VA medical facilities use the same method to ration outpatient care? In your response, please identify the benefits/advantages and drawbacks/disadvantages of using system-wide methodology.
11b. Should all VA medical facilities use a facility-specific method for rationing discretionary outpatient care? In your response, please identify the benefits/advantages and drawbacks/disadvantages of using facility-specific methodology.

Congress should legislate eligibility reform to be phased in prior to, and fully implemented with the advent of national health care reform. At this point, all veterans should be able to access the full continuum of health care at VA, giving special priority to those veterans VA is best suited to serve--the aging, blind and spinal cord injury patients, veterans needing prosthetics, long-term mental health and PTSD treatment, substance abuse programs, etc.

Until that time, VA should uniformly, system-wide provide care to those categories of veterans Congress has established for which VA is mandated to provide care, and criteria for the determination of who will

receive discretionary care. No lesser priority categories of veterans should receive care, when higher priority patients are turned away at other VAMCs because of overloaded appointment schedules. Resources should be shifted within the facilities and within the system to ensure continuity in the application of eligibility criteria, and efficient utilization of resources. The randomness of current methods of determining outpatient care eligibility and resource allocation are both unfair and wasteful.

Certainly, from a management perspective, this sort of massive coordination is a huge and difficult task to undertake. Isn't this the purpose and advantage, though, of having such an agency as the Veterans Health Administration? Until all service-connected and low-income veterans who wish to use the VA health system are able to access the full continuum of care there, VHA should not provide care for high income non-service connected veterans. If this means taking personnel and/or equipment out of a facility where it is underused, to be placed in another where it will be used efficiently, so be it. If this means providing fee-for-service cards to eligible veterans or transferring them to other VA facilities because the health care they need is not available locally or the time and space to provide this treatment is not available in the nearest VAMC, so be it.

The VA and its elected "board of directors" in Congress have an obligation to ensure that health care is provided to service-disabled veterans--those who have sacrificed the most for this nation. Every effort should be made system-wide to ensure that all service-connected veterans seeking treatment receive the health care they need before eligibility is opened to other users. If it is not possible for these veterans to receive this care within the VA, the agency should provide for it elsewhere. The individual veterans should be consistently able to receive the care they are entitled to at any facility within the system, whether this care is provided by the VA facility directly or it makes arrangements for this care through a non-VA provider.

12. ***If the method used to ration VA outpatient care should be uniform system-wide, what method should be used?***

First of all, with the dawn of national health care reform, it will not be necessary to ration VA health care provision, because it is likely that veterans will choose to use the easier-to-access national non-VA system once they are given the means to do so. In order to fill VA hospital beds and clinic appointment slots, eligibility reform should be enacted to allow VA to provide the full continuum of care to all veterans who choose to use VA. This should be implemented in a manner that targets the specific veteran populations that VA is best suited to serve, and should provide special attention to the needs of service-connected disabled veterans.

Secondly, the VA should move in the direction pursued by the private sector of providing less-serious treatments on an outpatient basis, because it is more cost-effective and allows patients to stay in their homes. The current eligibility hoops and hurdles often require VA physicians to admit veterans as inpatients to provide a particular type of care that the individual is not eligible to receive on an outpatient basis. This is wasteful, and doesn't represent good practices of medicine. This should particularly be a focus of VA as national health care becomes a reality.

Until national health care becomes a reality, however, the VA system as a whole should shift resources so that each facility can provide care to all veterans designated as priority eligibility. If it is simply not possible to provide outpatient care in this manner at any given facility, arrangements should be made to provide the care via non-VA providers. The bottom line is that veterans should not be turned away from care they are eligible to receive, no matter which VA facility they live near

13. ***Because of inconsistencies among and within facilities:***
    a. ***Do veterans understand VA provision of outpatient care?***
    b. ***Do VA employees (providers and non-providers) understand VA provision of outpatient care?***

Veterans certainly don't understand the eligibility restrictions on outpatient care and it seems that VA employees are similarly confused. To date, we have yet to speak to a single individual who can explain it succinctly. Even if the criteria for one facility are understood, they don't apply across the board system-wide. There is no consistent system to understand, and since it is so convoluted that no one can understand it, it cannot possibly be implemented consistently.

14. ***How can consistent outpatient health care provision decisions be achieved within and among VA facilities?***

Again, the logical answer to this question is that eligibility reform should be passed to allow all veterans seeking care at the VA to be able to receive the full continuum of inpatient and outpatient care. Until national health reform takes place, however, this will place impossible budget constraints on the VA, as swarms of veterans who currently have no other health care options attempt to get care at the VA. Eligibility reform must be enacted to coincide with implementation of national health care reform, however, in order to sustain some demand for VA health services.

Until this time, clear eligibility criteria should be mandated and applied system-wide by shifting resources to meet demand. This is the logical solution that any business management would utilize to make its operation cost-effective. Produce the services where they are most in demand, and purchase the services

where economies of scale cannot be established. But do not deny the veteran consumers their right to access health care.

15. Why should VA be concerned about inconsistent decisions on provision of outpatient care among VA medical centers?

In applying eligibility criteria differently across the nation, the VA is effectually institutionalizing discrimination against some geographic groups of veterans. If evaluated more closely, it is likely that demographics would indicate economic trends, as some areas of the country are more economically depressed than others. In general, economically depressed areas tend to have large numbers of veterans, because many individuals enter the military to gain career opportunities and escape economic hardship. When disability or discharge due to military downsizing occurs, these veterans return home to the same limited opportunities for achieving economic wellbeing, and therefore become dependent upon VA health services. In-depth demographic analysis may indicate economic discrimination based upon geography in VA health care rationing.

16. Why should VA be concerned about inconsistent decisions on provision of outpatient care within VA medical centers?

In general, those veterans attempting to access health care through the VA are poor and are uninsured or underinsured. These veterans are likely to have no other means of accessing health care services. Again, the VA was not designed to be, has never been, and should not be all things to all veterans. But it does represent our nation's commitment to assist those citizens who served our nation, regardless of social or economic status. Those who have sacrificed the most of their physical, mental or economic welfare should receive priority care at the VA.

Many veterans have become so frustrated with the VA and its inconsistencies that once another option for accessing health care services comes along, such as national health reform, they will leave the VA for providers they view to be more responsive. If all veterans leave the VA and don't return, its existence will become moot and it will cease to exist, just as did the Canadian veterans' health system. Although it doesn't feel market pressures yet, the VA, like any other business struggling to compete, will need to focus on customer service and patient satisfaction. VA needs to begin addressing this issue immediately, because its current reputation certainly does not exude consumer-friendliness, and therefore it has a lot of ground to make up.

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VETERAN ACCESS TO VA OUT-PATIENT HEALTH CARE

WASHINGTON, D.C. JULY 21, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States I wish to thank you for inviting us to participate in today's important oversight hearing. The lack of access to out-patient health care for non-service connected and medically indigent veterans is a long standing concern of the VFW. Thus, we are gratified at being asked to take part in today's hearing which is directed toward investigating the consequences of the current out-patient care eligibility standards for America's veterans.

The VFW strongly supports immediate liberalization of the eligibility standards which pertain to veterans health care, to include out-patient care. It is our view that current law establishing veterans health care entitlement and eligibility is counter-productive with respect to improving the VA system's quality, efficiency, and accessibility. It is well known that veterans access to VA health care is fragmented and unequal throughout the system. While a given veteran may receive care at one VA medical facility, he cannot get the same care from another. Medically indigent veterans are entitled to in-patient care but denied out-patient medical care except for pre- and post-hospitalization visits or to "obviate" the need for hospital admission. As is confirmed in the July 1993, draft GAO report addressing variabilities in out-patient care eligibility and rationing decisions, the standards applied to determine when out-patient care is necessary to "obviate" the need for in-patient care is vague at best and applied with absolutely no consistency throughout the VA health care system. Further, even service-

connected veterans with disability ratings of less then 50% have the same restriction for ambulatory care for any condition not related to their service incurred disabilities. No veteran is entitled to nursing home care.

The VFW also emphasizes that eligibility does not mean that a veteran will have access to the system. Eligibility for health care only means that VA may provide services if space and resources are available. After more than a decade of budget shortfalls VA's space and resources are limited, particularly in the sunbelt states. Thus, a veterans eligibility to health care is meaningless in a number of states where the space and resources are no longer available. Even entitled veterans are subject to tacit rationing of health care services due to constraints on space and resources. Long waits for clinical appointments and elected surgeries effectively deny care to many legally entitled veterans.

This abhorrent situation has been brought about through inadequate funding through the years and has resulted in the denial of out-patient care to veterans. This dollar-driven method of deciding access disregards physicians' professional judgment and veterans' immediate health care needs. Because of inadequate resources many VA facilities provide out-patient care to non-service connected patients only in emergencies. This situation is clearly not in keeping with proper compassion or modern medical practice and is totally unacceptable to the Veterans of Foreign Wars.

Mr. Chairman I would now incorporate into this statement the VFW position paper addressing improved access to VA health care. It is in keeping with current National VFW Resolution No. 719, entitled "Eligibility Reform For Access to VA Health Care," and carefully delineates the VFW's views with respect to eligibility reform:

VFW POSITION PAPER

IMPROVED ACCESS TO VA HEALTH CARE

VFW Resolution No. 719 (attached) is entitled "Eligibility Reform for Access to VA Health Care". This resolution highlights the VFW thinking in the matter of reforming the current laws and regulations governing access to VA health care. It establishes a firm position which we can use to negotiate toward our goal of improving such access. As with any resolution, it outlines the problem and offers suggested solutions, and calls upon the appropriate body to provide the relief requested.

Resolution No. 719 consists of the eight clauses leading up to the "BE IT RESOLVED" conclusion. The first three of those introductory clauses address the underlying problems as the VFW sees them. Let's begin with the first of those three:

– "WHEREAS, the existing laws governing eligibility for access to VA health care are clearly illogical in that some veterans are eligible for certain types of VA medical care and not another; and"

This opening clause summarizes the fundamental inequities of the VA health care delivery system today. It flies in the face of logic that certain of our veterans applying for care to VA are eligible to be treated as an inpatient, yet there are severe restrictions on providing those same veterans with the benefit of outpatient care. How can the credibility of VA as an institution continue when its admission policies are arbitrary to the point of discrimination?

The second of those three introductory clauses which outline the problem is as follows:

– "WHEREAS, those same rules governing eligibility virtually ensure that VA is unable to provide a full continuum of care to many who approach it, a situation which is contrary to sound medical practice; and"

Now that we have justifiably assailed the rules governing access, we are driving home the point that the capriciousness of those laws jeopardize the health of many veteran patients. If VA is able to evade responsibility for the full range of needed treatment to be provided to a veteran patient, consider the implications. Think of that veteran who recognizes that he is ill, yet refrains from seeking care from VA since he is justifiably confused about his possible entitlement, or lack of it, to outpatient care. When he finally approaches VA, his condition has deteriorate to the point where he requires treatment as an inpatient. Such a circumstance is clearly contrary to sound medical practice as is stated in our second "WHEREAS" clause.

The third of our introductory clauses homes in on the underlying problem which has brought us to the present sorry state of affairs vis-a-vis VA health care. It states as follows:

– "WHEREAS, the continued failure to adequately fund the VA health care delivery system according to its needs exacerbates the problem by forcing VA to increasingly ration the care it does provide; and"

Increasingly starved for the money it needs to do the job right, VA naturally reacts like any other institute which is hard pressed. First it cuts the fat, and then it continues to cut closer and closer to the bone. Medically desirable services are the first to go, and then substitutions, postponements, and treatment mode selectivity take their toll. That is where VA finds itself today.

The next four clauses of VFW Resolution No. 719 show where we are coming from as an organization. If we are going to nudge the VA and the Congress in the direction of eligibility reform, we have to be a part of the process. Since both VA and the Congress have been slow to act, we are putting our thoughts on the table upfront. While we may not get it all, there should be no doubt in the minds of both the Agency, the Congress, and the Administration about where we feel eligibility reform ought to start.

The first of these four clauses states as follows:

-- "WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement in law to access the full continuum of VA health care; and"

The VFW agrees with the prevailing consensus that some form of national health care is coming. It may be closer than any of us think. For VA to survive in such an environment, we feel that an expanded universe of veterans ought to be able to choose VA as their primary health care provider.

As we proceed further in examining the assumptions of Resolution No. 719, we need to pause here to differentiate between two terms. The first of these is "entitlement" which establishes the legal right. However, that "entitlement" must be further confirmed by the establishment of "eligibility". The differentiation in their meaning in Resolution No. 719 should become clear as we go on.

For example, the second clause of these four begins to define the concepts of "entitlement" and "eligibility" more precisely as follows:

-- "WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100 percent, as well as those veterans in receipt of VA pension, and those nonservice-connected veterans whose lower incomes currently qualify them for limited access via "means testing"; and"

There is no room for misinterpretation there. All service-connected veterans, all veterans in receipt of VA pension, and all nonservice-connected veterans already eligible for access to VA because of their lower incomes now should access the full continuum of VA health care. This would bring uniformity and do away once and for all with the present fractured system. VA would benefit by being placed in a position for the first time to be able to quantify the actual need for its services.

Next, Resolution No. 719 focuses on the remaining veteran population, those who cannot establish their eligibility to exercise their mandated entitlement to VA health care as do those defined immediately above. That clause reads:

– "WHEREAS, we believe that the remaining expanded universe of veterans with this mandated entitlement could establish their eligibility by some form of payment option, such as third party insurance, Medicare, out-of-pocket payment, or even by payment of medical insurance premiums directly to VA; and"

Simply stated, Congress should fund the VA medical care provided to those service-connected, on pension, and those with lower qualifying incomes. The other potential sources of reimbursement to VA, from the remaining universe of veterans as noted above, would serve to infuse additional dollars into the system. Additionally, we believe that the access of these additional veterans would serve to reinforce the system by expanding the patient mix, which would serve to keep VA competitive in the various medical specialties.

The penultimate clause pins the Congress, the Administration, and VA down by defining clearly what the VFW means by the full continuum of VA health care. That clause is quoted as follows:

– "WHEREAS, we believe that those veterans who establish their eligibility via one or another of the methods outlined above are entitled to the full continuum of VA care which is defined as ranging from preventive through nursing home care, and which recognizes the VA as "case manager" for the full range of ancillary services as well; and"

There is no "wiggle" room left there. No matter the outcome in terms of redefining eligibility for VA health care, those veterans who are accepted for that care should get it all without qualification.

The final narrative clause in Resolution No. 719 reminds VA, the Congress, and the Administration that the VFW is not alone in recognizing that something must be done in the matter of eligibility reform. The Commission on the Future Structure of Veterans Health Care, assembled by the former Secretary of Veterans Affairs himself, is in our corner on many of these issues. Thus, the final clause spotlights that point as follows:

– "WHEREAS, the Commission on the Future Structure of Veterans Health Care corroborated most of these points, especially the need for eligibility reform and the furnishing of a full continuum of care to veteran patients in its report to the Secretary of Veterans Affairs; now, therefore"

Which leads us to our Resolve. The mandate of the Veterans of Foreign Wars of the United States, approved by the delegates to its Convention. Resolution No. 719 concludes as follows:

– "BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility for VA health care by using the considerations raised in this Resolution as the basic building blocks to achieve that goal."

Attachment: VFW Resolution No. 719

11/92

Mr. Chairman, this concludes my statement. Once again, I wish to thank you and the members of this Subcommittee for allowing us to take part in today's important oversight hearing. A germane resolution is appended to this statement for your review and I would be happy to respond to any questions you may have.

RESOLUTION NO. 719

ELIGIBILITY REFORM FOR ACCESS TO VA HEALTH CARE

WHEREAS, the existing laws governing eligibility for access to VA health care are clearly illogical in that some veterans are eligible for certain types of VA medical care and not another; and

WHEREAS, those same rules governing eligibility virtually ensure that VA is unable to provide a full continuum of care to many who approach it, a situation which is contrary to sound medical practice; and

WHEREAS, the continued failure to adequately fund the VA health care delivery system according to its needs exacerbates the problem by forcing VA to increasingly ration the care it does provide; and

WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement in law to access the full continuum of VA health care; and

WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100%, as well as those veterans in receipt of VA pension, and those nonservice-connected veterans whose lower incomes currently qualify them for limited access via "means testing"; and

WHEREAS, we believe that the remaining expanded universe of veterans with this mandated entitlement could establish their eligibility by some form of payment option, such as third party insurance, Medicare, out-of-pocket payment, or even by payment of medical insurance premiums directly to VA; and

WHEREAS, we believe that those veterans who establish their eligibility via one or another of the methods outlined above are entitled to the full continuum of VA care which is defined as ranging from preventive through nursing home care, and which recognizes the VA as "case manager" for the full range of ancillary services as well; and

WHEREAS, the Commission on the Future Structure of Veterans Health Care corroborated most of these points, especially the need for eligibility reform and the furnishing of a full continuum of care to veteran patients in its report to the Secretary of Veterans Affairs; now, therefore

BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility for VA health care by using the considerations raised in this Resolution as the basic building blocks to achieve that goal.

Adopted by the 93rd National Convention of the Veterans of Foreign Wars of the United States, held in Indianapolis, Indiana, August 14-21, 1992.

Statement of

Michael F. Brinck
AMVETS National Legislative Director

before the

House Veterans Affairs Subcommittee on
Oversight and Investigations

regarding

Veterans' Access to VA Outpatient Care
and
Related Issues

July 21, 1993

Mr. Chairman, thank you for inviting AMVETS to testify today. The questions you posed were interesting and provocative. We welcome the opportunity to reply.

The inconsistent availability of VA outpatient treatment is the consistent theme throughout your list of questions. Because of that, AMVETS does not feel it is necessary to address each question in detail, but rather to acknowledge and agree that there are certainly inconsistencies in the delivery of outpatient care throughout the VA medical system, both within individual medical centers and among the system as a whole. Does AMVETS object to this inconsistency? Absolutely. The real question is, what is the method to ensure reasonably equitable access throughout the VA system?

AMVETS and most other veterans service organizations have long held that eligibility reform is key to providing consistent access to the VA medical system. Absent eligibility reform, it can only be business as usual, including the access equity problems you have noted.

AMVETS, along with most other veterans service organizations has been begging for eligibility reform for years. So far, only the VSO's have publicly stated their positions on eligibility reform. Each time we state our case, the government merely nods politely and changes the subject. Where is the VA's reform plan? Are we the only ones willing to discuss this most basic issue?

To date, we have only seen increased fragmentation of the eligibility through addition of special cases like Agent Orange and ionizing radiation, POW's, Persian Gulf veterans and sexual trauma. While we support treatment for all these veterans, it illustrates the difficulty faced by VA. Does AMVETS agree with that fragmentation? No. But we understand both why and how it has happened. We believe that, given sufficient funds, VA would be happy to treat all veterans. But why do we feel eligibility reform is the foundation for fixing VA medicine?

First, the lack of eligibility reform and its attendant inconsistencies in the ability to access VA care is due to insufficient funding from the Congress and successive Administrations. The inconsistencies you addressed in your questions must be laid primarily at the foot of those charged

with providing the funds for medical care. It is Congress's obligation to ensure that VA operates under a basic set of rules that define the core beneficiary population and provides reasonable access equity throughout the system. Because of decreased buying power due to insufficient funds, VA has had to slice the patient pie into smaller and smaller pieces to retain some semblance of order throughout the system.

Second, access equity demands that both the provider and the potential consumer know and understand what is required to become eligible for treatment - whether inpatient or outpatient. Some of your questions alluded to this fact. And we are sure that each member of this committee has heard stories from constituents about the difficulties and absurd logic encountered when trying to get into the VA system. The current eligibility system is a patchwork of rules that can only be interpreted by someone skilled at reading electrical wiring diagrams. Common sense demands that rules be easily interpreted by both VA and the veterans.

Third, access is hampered by eligibility rules that require a continuing determination of service-connection. We all know of the 600,000 case backlog in adjudication, but let's not forget the recurring need to determine whether additional ailments need to be determined as service-connected to receive treatment even though the veteran is already in the system. In other words, first its hard to get into the system, and once there, the rules under which the system operates does not allow the staff to care for the whole person. It is time the adjudication process get fixed to ensure that a veteran does not wait six to twelve months before being declared eligible for treatment.

Your questions also raise practical issues that go beyond eligibility and funding. In a system as large as the VA, it is probably impossible to grant access to care on an equal basis both within the individual medical center and among the several centers. Variations in staff composition, facility equipment, design, age, location, sharing agreements, medical school affiliations, the amount of volunteer help available, the political influence of its Congressional delegation, the aggressiveness of its management and many other factors will cause variations in access. For instance, in addition to staff who specialize in psychiatry, a VA mental health institution may have a small general medical staff to care for its patients. Obviously, veterans in

the area will not have the same access to the wide spectrum of medical specialties as those seeking treatment at one of VA's large acute care medical centers.

Additionally, VA needs to pay closer attention to sensitizing some of its staff to veterans' needs. We continue to hear of staff who tell veterans they resent having to sign off on a disability rating because the veterans is going to get all this free care. Such dog-in-the-manger attitudes must not be tolerated and VA managers must severely discipline those employees.

AMVETS continues to support the concept of regionalization and shifting missions of facilities to make the best use of VA resources system-wide. We feel that de-emphasizing the large multi-specialty acute care medical centers in favor of more numerous satellite and mobile clinics will significantly increase access to care for all but the hardest-to-serve veterans. And while we continue to support non-VA fee-basis care limited to those hardest-to-serve, we cannot support that method of delivery for all veterans because it will destroy the VA system - not just the hospitals, but also the basis for research and development, health professional training and other related entities.

Several of your questions implied that VA was seeing many high income or lower eligibly category veterans at the expense of Category A veterans. A review of the FY 1992 Summary of Medical Programs shows that of the nearly 3 million applications for treatment in the VA system, only 60,262 - including about 44,000 inpatient requests - were from discretionary category veterans. That is about 2% of the total. Clearly, VA is not being swamped by discretionary category veterans. Also, the Survey of Medical System Users Report of 1990 showed that only 30% of those treated in VA facilities had employment income and over 54% had personal net assets of less than $20,000. Coupled with statistics on the ages of those being treated, it is clear that VA's core beneficiary population remains the older and poorest of veterans.

Mr. Chairman, to summarize, AMVETS looks forward to working out an eligibility reform package prior to any other drastic changes in how VA does business. It is the basic building block, along with Congressional support, of the VA. Finally, while we appreciate and accept many of the statements made in your questions, we do not believe VA purposely attempts to create access inequities. Rather, they are the result of many years of underfunding.

That concludes our statement.

STATEMENT OF
C. WAYNE HAWKINS
DEPUTY UNDER SECRETARY FOR HEALTH
FOR ADMINISTRATION AND OPERATIONS
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

VETERAN'S ACCESS TO VA OUTPATIENT
HEALTH CARE
JULY 21, 1993

Mr. Chairman,

VA provides a wide range of services to veterans through its Ambulatory Care Programs. Outpatient services are provided at 170 medical center outpatient clinics, 53 satellite clinics, 44 community based clinics, 81 outreach clinics, 7 independent clinics and 6 mobile clinics. VA also provides outpatient services through its home care, homeless, and counseling programs. Where VA facilities are not accessible veterans with a high priority claim to service, VA contracts for care in the local community.

In Fiscal Year 1992 veterans made 24.2 million outpatient visits of which 23.1 million were visits to VA facilities and 1.1 million were contract fee basis visits. The total cost of outpatient care in Fiscal Year 1992 was $3.7 billion -- over 28 percent of the medical care appropriation. The President's 1994 budget request includes funding to support 24.9 million outpatient visits.

Public Law 100-322, the Veterans Benefits and Services Act of 1988, provided that outpatient medical services shall be furnished to certain veterans and may, at the discretion of the Secretary, be provided to other veterans to the extent resources and facilities are available in accordance with specified criteria. We have attached a description of current outpatient care eligibility rules including priorities for access to care and FY 1992 data on the disposition of applications for care.

Since 1988, VA medical centers have been applying the provisions of this legislation while dealing with resource constraints. Over time, in accordance with the intent of the law, VA medical centers have been required to reduce the amount of care being provided to "discretionary" veterans. Although there is regional and national oversight of workload distribution, VA medical centers must make decisions about restricting workload based on availability of funds at their own facilities.

Management decisions regarding decreasing discretionary workload are based on the requirements of the law and on budget analysis of the available funds, in conjunction with the mix of patients being treated, the utilization of programs offered, available human resources and their costs, and other uses of funds in a medical center. These decisions are based on a multitude of factors at each medical center. Strategies which individual medical centers may take to cope with decreasing budgets and to optimize their resources might include lengthening the time between scheduled outpatient visits, decreasing the number of times a subspecialty clinic is held during a week or a month, referring patients requiring a higher (or lower) level of care to a neighboring VAMC, and contracting for fee basis care.

During 1992 VA established networks of hospitals and clinics to improve delivery of services to veterans, to promote coordinated planning among medical facilities within geographic regions and to optimize resource utilization.

This initiative in addition to new Resource Planning and Management methodologies that are moving VA toward a prospective payment system should, over time, significantly improve the allocation of resources to equate more evenly with the case-mix of the individual medical centers. These initiatives will lay the groundwork for a much greater emphasis on managed care within the VA system where health care will be provided in the most appropriate setting to meet the patient's health needs.

Mr. Chairman, we have reviewed two recent GAO reports that addressed consistency of VA medical centers' determinations of eligibility for care and variations in the provision of care. While the degree of variability found is not desirable, we believe it is to be expected given current resource availability and the rules and laws governing access to care. We expect that the full implementation of VHA's Resource Planning and Management (RPM) system will help provide equal access to veterans in the same care categories, regardless of geography.

Attachment

OUTPATIENT CARE ELIGIBILITY

Public Law 100-322, The Veterans' Benefits and Services Act of 1988, provided that outpatient medical services "shall" be furnished to certain veterans and "may," at the discretion of the Secretary, be provided to other veterans to the extent resources and facilities are available in accordance with the following criteria:

(1) VA "shall" furnish outpatient care without limitation to: veterans for their service-connected disabilities; and, veterans rated 50% or more service-connected for any disability.

(2) VA "shall" furnish outpatient care for any condition to prevent the need for hospitalization; to prepare for hospitalization; or to complete an episode of treatment after hospitalization, nursing home care, or domiciliary care to: any 30% or 40% service-connected disabled veteran; and, any veteran whose annual income, as determined by Means Testing, is not greater than the maximum annual pension rate of a veteran in need of regular aid and attendance.

(3) VA "may" furnish outpatient care without limitation to: a veteran in a VA approved vocational rehabilitation program; a veteran who is a former prisoner of war; World War I and Mexican Border Period veterans; and, veterans who are in receipt of Aid and Attendance or housebound pension.

(4) VA "may" furnish outpatient care to prevent the need for hospitalization; to prepare for hospitalization; or to complete an episode of treatment after hospitalization, nursing home care, or domiciliary care to: any veteran rated 0% through 20% service-connected for treatment of a nonservice-connected condition; veterans exposed, during service in Vietnam, to a toxic substance or ionizing radiation following the detonation of a nuclear device; veterans whose annual income, as determined by Means Testing, is greater than the maximum VA pension rate of a veteran in need of regular aid and attendance, but less than the threshold amount which identifies a veteran as "discretionary;" and, "discretionary" veterans subject to a co-payment for each outpatient visit.

(5) Public Law 102-585, Veterans Health Care Act of 1992, provides that: during the period through December 31, 1995, the Secretary "may" provide counseling to a woman veteran who the Secretary determines requires such counseling to overcome psychological trauma; and, the Secretary "shall" provide, upon request of a veteran who served in the Persian Gulf Theater, a health examination and consultation and counseling with respect to the results of the examination.

(6) Public Law 102-405, Veterans' Medical Programs Amendments of 1992, provides that, subject to availability of funds, the Secretary "shall" furnish marriage and family counseling services to: veterans who were awarded a campaign medal for active-duty service during the Persian Gulf War and the spouses and children of such veterans; and, veterans who are or were members of the reserve components who were called or ordered to active duty during the Persian Gulf War and the spouses and children of such members.

2.

Priorities for Access: When the demand for care is consistently greater than the care which can be provided with available VA resources, restrictions on accepting new applications can be imposed by health care facility directors. In such event, admission of applicants to outpatient programs is restricted by not accepting applicants from priority categories below the priority level where appropriate care can be provided within available resources. These restrictions may be applied by clinical sub-specialty or by service. Those persons with emergent conditions requiring immediate medical attention are provided emergency care without regard to priorities. The initiation of care in an outpatient program or the continua- tion of care after its initiation is based on a professional determination of the need for care, and the patient is scheduled or seen according to the following priorities and in sequence indicated within these priorities as required by 38 U.S.C. Section 1712(i).

(1) PRIORITY I:

(a) Veterans who require care for their service-connected disabilities (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service);

(b) Veterans who are 50% service-connected or more and require care for any condition;

(c) Veterans who have suffered an injury, or an aggravation of an injury, as the result of VA hospitalization, medical or surgical treatment, or while in a vocational rehabilitation program and such injury or aggravation results in additional disability to the veteran;

(d) Veterans who are rated 30% or 40% service-connected,

(e) Veterans in the mandatory category for care, whose income is less than the maximum VA pension rate (Aid and Attendance).

(2) PRIORITY II:

(a) Veterans who are rated less than 30% service-connected or receiving a compensation examination;

(b) Veterans who are being examined to determine the existence or severity of a service-connected disability; or

(c) Female veterans who are eligible for counseling of sexual trauma under 1720D of Title 38, U.S.C.

(3) PRIORITY III: Veterans who are former POW's or require medical care of a condition possibly resulting from exposure to Agent Orange (Vietnam), Ionizing Radiation (WWII), or Environmental Contaminates (Persian Gulf).

3.

(4) PRIORITY IV: Veterans who served during the Mexican Border Period or World War I; veterans in receipt of increased pension or additional compensa- tion or allowances based on the need of regular aid and attendance.

(5) PRIORITY V: Discretionary veterans whose income exceeds the pension rate of a veteran in need of regular aid and attendance but which is less then the Means Test threshold.

(6) PRIORITY VI: All other Discretionary veterans.

(7) PRIORITY VII:

(a) Allied beneficiaries;

(b) CHAMPVA beneficiaries;

(c) CHAMPUS beneficiaries;

(d) Beneficiaries of other Federal agencies; and,

(e) Non-Veterans.

Patients Treated or Denied Care: The below data is provided for Fiscal Year 1992.

Applications for Care:	2,982,871
Received Hospital Care:	567,193
Received Nursing Home Care:	7,910
Received Domiciliary Care:	7,790
Received Outpatient Care:	2,272,796
Not in Need of Care:	40,105
Cancelled Application:	52,747
Not Eligible for Care:	6,734
Trmt Modality not Available:	22,881
Referred to Another Facility:	4,115
Not Agreeing to Deductible:	304

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VETERAN ACCESS TO VA OUTPATIENT CARE AND RELATED ISSUES

JULY 21, 1993

Question 1: According to GAO, VA could reduce inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic make-up of eligible veterans requesting services at each center.

Do you agree or disagree?

How could VA better match medical centers' resources to the volume and demographic make-up of eligible veterans requesting services at each center?

Does VA already collect the information that is needed to provide a better match-up between medical centers and available resources?

What information not now being collected by VA is needed in order to provide a better match between medical centers and available resources?

Does VA have or lack the management tools needed to significantly improve equity in access to care?

What tools does VA need, but lacks today, to significantly improve equity in access to care?

Answer: VHA agrees that VA could reduce inconsistencies in veterans' access to care by matching medical centers' resources better to the volume and demographic make-up of eligible veterans requesting services at each center. For the FY 1994 medical care appropriation, VHA has initiated the Resource Planning and Management (RPM) system for use in allocating resources to VA medical centers. The RPM system is a workload and patient-based management system that is intended to improve the management of limited resources. It is prospective in terms of policy, workloads and costs. The new system is VHA's initial step in matching medical centers' resources better to the volume and demographic make-up of eligible veterans requesting services at each center.

In the RPM system, VHA uses the Cost Distribution Report (CDR) for cost information and such internal files for workload as the Patient Treatment File (PTF), Outpatient Care File (OPF), Patient Assessment File (PAF) for Long Term Care and Patient Registeries (i. e., AIDS, Dialysis). These information systems need refinement and VHA has plans for improving its costs and workload systems.

An important component of VHA's plans is the start of a new real-time workload reporting system called Event-Driven Reporting (EDR) in Fiscal Year 1994. VHA is also working on the development of a patient-specific costing system--the DMMS/DSS (Decentralized Medical Management System/ Decision Support System). The use of real-time workload monitoring and analysis system, such as Event-Driven Reporting, scheduled for initial national implementation in FY 1994, and future patient-specific costing will enable VHA to have improved and more timely information for its management of medical care resources.

The RPM system is being used to allocate medical care resources better. However, enactment of the President's proposal for national health care reform, which would effectively reform VA eligibility rules, is needed to achieve uniformity of access to care.

Question 2: Back in February, 1991, I asked VA about inequities in veteran access to outpatient care. At that time, VA told me a three year process had been initiated in FY 1989 to promote the uniform geographic availability of medical resources to veterans; the last of three years of discrete VA facility-specific adjustments for equity of access was FY 1991.

Why did this VA effort fail to achieve equity of access?

Why would any other VA effort to achieve equity of access be more likely to be successful?

Answer: The process that was used from FY 1989 to FY 1991 to promote the uniform geographic availability of medical care resources to veterans by VHA was based upon an adjustment process relative to discretionary, that is category B and C, workload. With budget constraints in the last few years, the discretionary workload has decreased to a minimal level. The RPM system will deal further with providing a national balance of resources for the VA medical care system through the review and adjustment of high outlier unit costs and low outlier unit costs. We are accomplishing this through a shift of $20 million in FY 1994 (-$10 million from high outliers and +10 million to low outliers). We will continue to use the outlier review process under RPM to shift funding throughout the VA system from high cost to low cost outlier facilities.

As discussed in the response to Question 1, VA believes enactment of the President's national health care reform proposal is needed to resolve issues of access to care.

Question 3: In 1991, VA also reported to me that beyond FY 1991, it would, "integrate the principle of equity of access into the resource planning and management (RPM) process being prepared to replace the previous resource allocation system. RPM will be used to identify gaps, overlaps, or imbalances in program and services. The new process includes the development of a National VA Health Care Plan which will be the basis for adjustments, additions, or deletions to the missions and programs of VA medical centers." This, "program initiative is being designed to assure that comparable levels of care are given to veterans in all areas of the country."

Discuss VA's National Health Care Plan and how will it be used as the basis for adjustments, additions, or deletions to the missions and programs of VA medical centers.

How will this "program initiative assure that comparable levels of care are given to veterans in all areas of the country."

Answer: The development of mission categories as a means to identify gaps and overlaps in services is one of the first steps in a shift to operating a managed care system. We have developed a clinical mission template with six mission categories and associate programs and services for two purposes: (1) classifying the facility into a mission category and (2) assessing availability of programs and services once the mission has been assigned. The mission assigned reflects a facility's current capabilities, not necessarily its definitive role. Each facility will be assigned a mission that, together with the missions of other facilities, will provide a range of primary, secondary and tertiary care within a geographic area. Assignment of preliminary mission categories currently is being done by the Regional Directors for submission later this fiscal year.

The template proposes that each facility must provide primary care and each of the six mission categories begins with primary care. The template then differentiates between core and referral level services. Core services are provided locally and will be made available to veterans residing in each facility's catchment area. Referral service address less frequently occuring, or more complex, conditions for which specialized personnel, facilities, and support services are needed. Certain facilities will provide referral services to veterans in their own and other catchment areas. Referral programs and services are defined as either network, regional or national resources and will be available at those respective levels.

Once a preliminary mission is assigned to a facility, it will be used to identify gaps in basic primary care services. Any referral program that is inconsistent with the VAMC's mission assignment can then be reviewed for appropriateness for that VAMC. Through a systematic needs assessment, the need for new programs and the need for consolidation of programs can then be determined.

Question 4: What is the status of VA's new Resource Planning and Management (RPM system?

How will RPM be used to identify gaps, overlaps, or imbalances in programs and services? What gaps, overlaps, or imbalances in programs and services have been identified by VA?

When will the RPM system be fully implemented?

Answer: VHA's Resource Planning and Management (RPM) system is being introduced in the FY 1994 budget allocation process. FY 1994 is the transition year for RPM. There is a great deal of work to be done to improve the information systems, to train the staff, and to develop national program policies. The new system--RPM--is expected to help us better identify our resource requirements in the future. It will require three years to fully implement the new system.

During the FY 1994 budget allocation process we have taken initial steps to identify and fill gaps in programs and services. Some resources are being moved from acute and chronic inpatient to outpatient, chronically mentally ill and AIDS. In future years, VHA's strategic planning process will drive policy guidance for RPM and identify any additional gaps, overlaps or imbalances in programs and services.

FY 1994 is the first step in a three year transition and development process. It will take two years to transition away from the historical budget data and institutionalize a patient care workload funding base. The field, VSOs and the Congress respond best to advance notice about change in process and information systems. Any major shifts in workloads, budgets and missions of individual medical centers require support within the Department, OMB and the Congress to be successful.

Question 5: Your statement refers to "a much greater emphasis on managed care within the VA system where health care will be provided in the most appropriate setting to meet the patient's health needs."

To what extent is VA not providing health care in the most appropriate setting today to meet the patient's health needs? Why?

What changes are needed within VA so that health care is provided in the most appropriate setting to meet the patient's health needs? Describe VA's current plans to make these changes.

Answer: Both internal and external analyses of our patient treatment records have shown that many veterans are hospitalized who could be treated more effectively in outpatient settings, were such options more readily available to clinicians. Reasons for admitting veterans rather than treating them on an outpatient basis involve complex eligibility rules, accessibility for veterans who may be admitted to avoid lengthy round trips, VA's hospital-based structure, which has fostered a predilection toward inpatient, acute care and a lack of non-institutional alternatives to institutional care.

Under current rules, only veterans with a 50 percent or greater service-connected disability have unlimited access to outpatient care. Other veterans whose care is mandated are eligible only for treatment of their service-connected conditions, for pre-hospital workups or follow-up aftercare, or "to obviate the need" for hospitalization. These rules are subject to misinterpretation, difficult to administer, and also make it difficult to deliver managed and primary care.

The needed changes flow from the obstacles to providing effective care in the most appropriate setting. The President's National Health Reform proposal will incorporate needed changes to VA eligibility statutes. With eligibility reform in place, VHA can adopt a managed care approach to reorganizing the federal system of veteran care. A critical element in the success of managed care is the ability to provide primary care and minimize specialty care. A primary care physician or team can provide much of a veteran's care in the outpatient setting, while serving as the point of access to specialty care when appropriate.

As part of this reform effort, VHA will explore the possibilities for increased access to outpatient primary care through establishment of additional community-based clinics. At the same time VHA will test the feasibility of expanding non-institutional alternatives with additional home care programs.

Question 6: Identify the benefits which have resulted from VA establishing networks of hospitals and clinics during 1992.

Answer: VHA has recently established area health care networks to provide focal point for integrating the planning and delivery of a comprehensive range of health care services to eligible veterans among medical centers in geographic proximity. Each network consists of three or more medical centers, with one being a tertiary care center. Surrounding these tertiary centers are facilities providing general medical, surgical and psychiatric treatment at the primary and secondary levels.

The networks have been working to improve transfers and referrals among medical centers. Many of the individual networks have developed arrangements that have made referrals more convenient and appropriate for the physicians and patients involved. The membership of many of the networks also have developed routine transportation systems. The networks currently are reviewing the inclusive medical centers' missions and programs to ensure that the full continuum of health care services exists and is accessible to every eligible veteran.

The networks, which are independent of one another and are under the direction of the Regional Directors, have been pursuing many other initiatives that will benefit the veterans and the VA system. They are looking at sharing agreements among medical centers for staff and equipment, improving computer systems to facilitate the transfer of information, reducing compensation and pension examination waiting times and improving health programs and long-term care for women. There are many other initiatives that the networks are pursuing and each has the potential of reducing costs and improving patient access and quality of care.

Question 7: How much inconsistency in veterans' access to VA care is acceptable?

What is VA's goal for veterans equity of access to VA care?

Answer: No level of inconsistency in veterans access is acceptable.

Ideally, all eligible veterans should have access to quality care at a VA facility. However, in today's budgetary environment it is not feasible that all services can be provided at every facility. During the next submission of the Regional Strategic Plans, emphasis will be placed on the identification of gaps and overlaps of clinical services within a Veterans Service Area (VSA). Evaluating existing clinical services will provide VA the opportunity to assess available resources and determine the most appropriate distribution. One of VA's major goals is to insure that all VA facilities have the capability of providing primary care to veterans. Within each VSA, the intent is to insure that all tertiary services will be available to eligible veterans.

Question 8: Please provide the results of the Limitation of Care Survey conducted in the Western Region.

Answer: In the preliminary report of a study of access to care at Western Region Facilities, Associate Chiefs of Staffs for Ambulatory Care report that care to veterans has been restricted to those eligible veterans with the highest priority for care and in most urgent need of care for the last several years. The number of days until the next available appointment date--a measure of restricted access--ranges from an average of 27 days for minor surgery to 83 days for gastroenterology-urology services. Differences between types of clinics were found to be significant statistically. In eight clinics surveyed, the average time until next appointment ranges from 28 days to 109 days. Differences among hospitals were not found to be significant statistically.

These data will be tracked over time and at all VA hospitals as a measure of access to care in the VA system. The evaluation of the data has not been compared to other U.S. hospitals in the private and public sectors. Finally, average waiting times also might be better explained taking funding per bed, availability of personnel and other variations into account. This research is underway.

QUESTIONS SUBMITTED BY
THE HONORABLE SPENCER BACHUS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VETERAN ACCESS TO VA OUTPATIENT CARE AND RELATED ISSUES

JULY 21, 1993

Question 1: Of the 24.2 million outpatient visits made during FY '92, how many "discretionary" veterans received outpatient care?

Answer: During FY '92, there were 308, 865 "discretionary" visits. These were non-service-connected patients who were not in receipt of VA monetary benefits and did not qualify as low income veterans. During this period the VHA reporting systems did not break down the workload into categories as defined by Public Law 100-322, Veterans Benefits and Services Act of 1988. The workload was shown in the means test categories required in Public Law 99-272, Veterans Health-Care Amendments of 1986. This change in reporting systems was installed at all VA medical facilities as of October 1, 1993. Prior to October 1, 1993 service-connected veterans seen by the clinical staff for a non-service-connected condition were reported as "mandatory" workload because of their exemption from the means test. With the installation of the new software at the medical facilities, VHA will be able to determine at the national level whether patients receive medical care as "mandatory" or "discretionary" in accordance with Public Law 100-322.

Question 2: The General Accounting Office has recommended that in the absence of eligibility reform, the Secretary should provide better guidance to centers so that clinicians can implement criteria with greater consistency. What steps are you taking to implement this recommendation?

Answer: The Department believes that enactment of the President's national health care reform proposal would be the best way to alleviate inconsistencies in eligibility determinations.

Chairman Evans to Dr. Lee

1. Your statement refers to a 1992 National Association of Veterans Affairs Physician Ambulatory Managers position paper on eligibility reform. What is the position of the National Association of Veterans Affairs Physician Ambulatory Managers on VA eligibility reform? What changes in eligibility are currently recommended by the Association?

The National Association of Veterans Affairs Physician Ambulatory Managers' position is stated in an abstract: Current VHA eligibility rules evolved around a model centering on episodes of hospitalization. They are very complex and interpreted in widely different manners throughout the country. This causes dissatisfaction and confusion among patients and providers. The National Association of Veterans Affairs Physician Ambulatory Managers (NAVAPAM) proposes a new patient-centered paradigm focusing on meeting patient needs in the most clinically appropriate setting for those considered eligible. Recommendations are made to achieve the new paradigm.

The changes recommended are centered around seven recommendations:

a. VA eligibility regulations should be rewritten to define an eligible population that can receive comprehensive care.

b. The numbers that should receive such care services should be as large as possible.

c. If it is absolutely necessary to restrict some services, consideration could be given to benefit "packages" at certain levels of eligibility that should be clearly defined and consistent across the system. This should be simple and easy to understand. It is a fall-back position to the ideal of comprehensive care, but could allow flexibility and some cost sharing.

d. New eligibility regulations should promote primary care, focusing on coordinated, comprehensive, longitudinal care. There should be continuity of care, with the goal of enrolling each patient in a primary care clinic where they are assigned to a single primary care provider. Failing that, there should be at least a consistent team. Care for each patient should encompass the entire continuum of care including inpatient, outpatient, and long term care. Validated preventive health care practices should be strongly emphasized. Shifts of resources and additional resources will be needed to accomplish these goals. More physician extenders may be needed. As a cautionary note, two systems which have aggressively offered this sort of care have been "over-subscribed" with patients presenting for care. Suppressed demand is probably high for quality primary care services.

e. The VHA role and eligibility changes should be delineated in the context of national health care reform.

f. Remove physicians and health care providers from the role of denying patients care.

g. Input into the process of rewriting VA eligibility regulations should have broad based representation, including representatives from the field, particularly ambulatory care.

h. Access to care across the entire system should not be constrained on the basis of geography.

If the cost of eligibility reform recommended by the National Association of Veterans Affairs Physician Ambulatory Managers reform recommendation has been estimated, please provide the estimated cost.

The National Association of Veterans Affairs Physician Ambulatory Managers has not estimated the cost of care provision.

2. According to your statement, 1,200 patients are on a waiting list for ambulatory care at Boise. What types of care do these veterans need and are they receiving the care they need from other non-VA providers?
The types of care needed by the veterans on the Boise waiting list are quite typical of the rest of our veteran population. They include hypertension, cardiac disease, pulmonary disease, various manifestations of neurological disorders, and some cancer patients.

Many of the patients cite the high cost of private medications as a major influence in their desire to receive care from the Department of Veterans Affairs. Although we have not done a comprehensive study of the patients on the waiting list, an informal survey has been done. Out of a sample of twenty-seven, three eventually did get enrolled at the Boise Veterans Affairs Medical Center. Two others have arranged to obtain care at other Veterans Affairs Medical Centers. Nineteen of the patients are receiving care from private entities. Five are not obtaining care of any sort. This proportion, five of twenty-seven, would be consistent with the figures of 15% to 25% that were cited in two literature references in my original testimony. 25% of the patients responding to a satisfaction scale indicated that they were very dissatisfied to satisfied. Twenty-four of the twenty-seven patients indicated that if they could be put in our clinic programs, they would still prefer to do that. This is consistent with the data provided by Dr. Zietler, indicating a high proportion of veterans who prefer to return to Department of Veterans Affairs care. Individual comments by the veterans indicate great dissatisfaction with their inability to access care here. In summary, our experience, and the published literature suggest that a relatively high proportion, between 15% and 25%, receive no care at all.

3. Your statement refers to your concerns about both access and discharge from care. Please discuss your concerns regarding discharge from care.

When it becomes necessary for medical centers to ration care, usually because of economic imperatives, the usual bars are placed at the point of access to the system. The speculation is that it is easier to deny patients access to the system that it is to sever existing relationships. However, in recent times, on several occasions, many medical centers have actually discharged patients for whom they were caring. The most common example of that, cited in detail by Dr. Zietler, was the discharge of stable patients who had at least some income (Category C non-service connected patients). Other medical centers have discharged stable patients, even if they had no income. While it is very difficult to deny care at the point of access, as I have already detailed, it is significantly more difficult to sever an ongoing therapeutic relationship. When the administration of the Boise Veterans Affair Medical Center made a determination that stable Category C patients had to be discharged, many of my own personal patients were in that group. I still vividly remember the real pain in discharging many of these patients. Two that are particularly memorable were a patient who, like myself, is part Native American. He was the water-master of the Big Wood River. We very much enjoyed seeing each other, in addition to dealing with his medical problems. Another was a hardworking employee of the state of Idaho who worked on a highway crew. He had moderate diabetes, and it was difficult for both of us to break the relationship we had. I not only knew him as a person and friend, but obviously had tremendous experience in dealing with his own manifestations of diabetes. Discharging patients in this fashion is obviously tremendously painful, and as Dr. Zietler has indicated, most of the patients would prefer to return to Veterans Affairs care, at least in the small to moderate sized medical centers.

RESPONSES TO QUESTIONS FOR MR. FRANK C. BUXTON
DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

1. **What criteria should be used to judge VA eligibility reform proposals?**

RESPONSE:

a. Eligibility for VA care should be based on medical and economic need and never on resource availability. VA should have resources to care for veterans who are **entitled** to care. Historically, VA has been constrained in its ability to render care because of resource limitations.

b. The eligibility for care in VA must be based in a holistic model which would treat the whole patient via a continuum of care. Fragmented health care delivery is a poor way to deliver care. The patient must be able to move among care models and services which are necessary to make him/her as well and/or as functional as possible.

c. There should be only two classes of veterans in an eligibility scheme, those that are **entitled** to care because of service connection, limited incomes, catastrophically disabled or sick or special categories such as WWI veterans, Agent Orange victims, those on pension, radiation victims, ex-POWs and those exposed to the hazards of the Persian Gulf war, and those who are **eligible** for care which includes all other veterans. Funding for those veterans **entitled** should come from appropriated dollars. The care for the remainder of the veteran population should come from reimbursement from third-party payers **including federal programs such as Medicare and Medicaid**, or from the veterans own resources.

2. **Please identify the changes in VA eligibility currently recommended by your organization.**

RESPONSE:

The "American Legion Proposal to Improve Veterans Health Care" contains the following recommendations regarding entitlement, eligibility and funding for health care in VA:

- VA health care should be considered an ***entitlement*** for service-connected care.
- The degree of service-connected disability should not be a factor in entitlement to care in the VA.
- All veterans with service-connected disabilities should have access to a full spectrum of health care services including, but not limited to preventive care, long term care, acute care, ambulatory care, specialized care, respite care and hospice care.
- Once a veteran has been determined to have a need for care in the VA, he or she must have access to a full spectrum of health care regardless of whether the illness or injury is service-connected.
- There should be only two classes of veterans for VA health care; those that are service-connected and those that are not service-connected.
- Any veteran without service-connected disabilities should have access to VA health care with payment by a third-party payer.
- Medicare, Medicaid and other federally funded health care financing systems must be considered third-party payers and be expected to reimburse the VA for care provided to non-service-connected veterans.
- Funds collected for medical services rendered must revert to the VA, or more appropriately, the VAMC which delivered the care, not to the general fund of the U. S. Treasury.

- Non-service-connected veterans not entitled to care under this proposal should be allowed to receive medical care in the VA for a charge based on the veterans' ability to pay.

- No veteran will pay deductibles or co-payments in conjunction with care received as a result of entitlement or for care reimbursed.

- Any veteran who suffers a catastrophic illness or injury, payment for which would render him/her destitute, or any veteran proven to be uninsurable, will receive care from the VA without charge.

AN AMERICAN LEGION PROPOSAL TO IMPROVE VETERANS HEALTH CARE

JANUARY 1993

74-312 O - 94 - 5

The American Legion ★ WASHINGTON OFFICE ★ 1608 'K' STREET, N. W. ★ WASHINGTON, D. C. 20006 ★

OFFICE OF THE
NATIONAL COMMANDER

A MESSAGE FROM THE NATIONAL COMMANDER OF THE AMERICAN LEGION

A major portion of the increasing national fiscal deficit is the effect of the ever escalating costs of rendering health care to the citizens of this great nation. Immediate action must be taken to reform our health care system on a national level before any attempts to reconcile the deficit will work. The new Administration is committed to support legislation which will help remedy this untenable situation.

The Department of Veterans Affairs' Veterans Health Administration is responsible for operating one of the nation's largest hospital and health care systems. This system, founded and dedicated to the care of our nation's defenders, consists of 172 medical centers plus nursing homes and outpatient facilities across the country. Fiscal problems have also plagued this health care delivery system. For a decade the system has required more and more money to care for fewer and fewer veterans. These increases have not allowed for the shrinking value of our health care dollars. Therefore, the Veterans Health Administration has found it necessary to enforce tight restrictions on access to the system. Although the system has become proficient at doing more for less, the result has been a virtual rationing of care. More and more veterans needing and deserving care have been excluded by a complex maze of eligibility requirements.

Just as the national health care system requires reform, the veterans health care system must also change. The eligibility guidelines for the system must undergo reform and the system must be funded in a manner which will not require rules which exclude any veterans needing care.

The American Legion has developed a plan to assist in changing the way the Veterans Health Administration delivers health care and to provide for survival of this vital national asset. This proposal is not a "cure-all." However, it puts forth recommendations which can start the system on a path to improvement.

Roger A. Munson
National Commander

An additional problem that confronts a veteran seeking health care is the accessibility of that health care. Health resources such as hospitals, clinics, equipment and specialized services and personnel should be geographically positioned to match veterans' needs and population distribution. Such resource distribution should provide the proper setting for the care rendered such as ambulatory, community, acute, extended or specialized care. These reapportionments may require facility mission changes in some cases

As an additional policy change, the needs determination and manipulation of resources should be bestowed upon local managers. This responsibility would imbue a stronger sense of "ownership" and therefore the concomitant accountability for cost and quality of care Such a system would nurture initiative and the incentive to produce and would confer accountability for the results of their leadership.

In addition, The American Legion supports the concept of resource sharing with other health care systems with the goal of enhancement of medical care to veterans. Programs such as lease, lease-purchase or sharing should be explored at the local level There should be no dicta to share resources from the VA Central Office in Washington, simply because the local facility would be in a much better position to evaluate resource capabilities and appreciate the needs of the catchment area veterans . At no time should the VA system merge with another federal provider such as DHHS or DoD. There should be no situation wherein the VA would lose ultimate control over the provision of care or the reaping of benefits The concept of "enhanced use" could be supported by The American Legion as a cost-containment measure on a case-by-case basis

The provision of quality care to veteran patients should come before any other consideration in the Veterans Health Administration Security of employees' positions, choice of location of facilities or parochial or "pork-barrel" interests must be tossed away when rebuilding a system which focuses on quality and requires a dedication of resources and a commitment to fundamental change where necessary The entire system must be dedicated to meeting or exceeding the expectations of its veteran clients The American Legion believes that the VA health care system can deliver quality care and maintain that quality given sufficient resources and guidance

In regard to human resources management in the VA, the Legion believes that the VA has the potential to develop a human resources program which can, at local levels and national levels, educate, train and retrain, reward and recognize excellent dedicated employees while maintaining a system of progressive discipline which will assure continued quality performance

The affiliation of VA health care centers with centers of educational excellence such as medical, nursing and allied health professional schools undoubtedly has the potential for improvement of patient care The presence of students, faculty members and other educators in the VAMC not only provides the students with an expanded patient population and a diversity of medical diagnoses, but

stimulates the staff to better professional excellence through example and the sharing of knowledge. Certain cost savings may also accrue through affiliation as well as the sharing of services and equipment. The American Legion appreciates the potential for improvement of patient care which can occur through professional school affiliations.

Department of Veterans Affairs research endeavors have long been supported by The American Legion. This research has benefited the veteran population as well as the private health care sector with studies in the areas of Alzheimer's disease, post-traumatic stress disorder, and particularly in prosthetics development. The American Legion supports the creation of research, educational and clinical centers in areas such geriatrics, mental illness, cancer, lung and heart disease.

The health care delivery system in the United States is crying out for reform and that reform must and will occur soon. Equality of access, quality and cost curbs must be elements in the reform of this present cumbersome, unfair and expensive system. A properly re-configured and administered VA health care system could well serve as a model for a new national health care system.

For further information on this proposal or other American Legion veterans benefits programs contact:

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THE ROLE OF THE VETERANS HEALTH ADMINISTRATION IN NATIONAL HEALTH CARE REFORM

The health care delivery system in the United States is in a pathetic and expensive state of disarray. Sick and poor citizens are unable to obtain adequate health services because of outrageous cost and misallocation of resources. Medical care costs in this country are rising at a rate double the rate of general inflation increase. Runaway costs have forced hospitals and other health care facilities out of business. Inadequate reimbursement rates have done the same. Government programs, presumed to be cures for bad delivery systems, are overspent and under funded Insurance premiums, deductibles and co-payments, including those for federal programs, have risen above the realm of affordability for many needy and not-so-needy persons in this country. Static pay scales for consumers, increased compensation for health care professionals, unemployment, the increasing use of expensive technology, the practice of defensive medicine and the treatment of such illnesses as AIDS and Tuberculosis have burdened national health care resources to the limit The time is right for national health care reform The Veterans Health Administration can play an influential role in this reform

The American Legion adamantly opposes any national health care reform proposal which would abolish or diminish the role of the Department of Veterans Affairs health care system. The Veterans Health Administration has been, and should continue to be, a source of the unique health care which veterans require The system must not be merged into any health care delivery conglomerate, public or private, in which the VHA would lose its identity, change its mission, or cease to exist as a source of health care for those who have valiantly served this country.

Several model systems have evolved in the rush to reform our nation's health care system. Some plans would put the onus of adequate health care on the individual's employer; others would follow the Medicare model with a mix of public and private health care funding; still others would be patterned after the "Canadian" reform, which funds health care for everyone at the national or provincial level. Each of the many plans may have its drawback or advantages. For instance, any plan to provide for "universal" health care by use of a "voucher" system may erode the infrastructure of the VA health care system and eventually cause its collapse. It bears repeating that The American Legion will vigorously oppose any system which would be to the detriment of veterans requiring health care. In addition, a properly funded and managed Veterans Health Administration might well serve as a model for a national health care system, a system predicated on an equitable balance of entitlement and eligibility for access, funded by a combination of public and private monies and available on the basis of health care need rather than resource availability or financial status.

The Department of Veterans Affairs health care delivery system has a proven track record in the ability to deliver quality health care at a cost well below that of the private sector. Recent studies have demonstrated that health care of equal quality can be delivered by the VA at costs which are 40% less than that of affiliated university hospitals Any plan to reform the nation's health care delivery system should utilize the cost-containment experience of the Veterans Health Administration.

"The VA health care system must be retained in any type of national reform."

HISTORY AND BACKGROUND OF DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE

Assistance to sick and disabled veterans by the various governments dates back to the mid-1600s, when the Pilgrims agreed to support those disabled by the skirmishes with the Indians. Individual states and communities have provided various benefits to veterans since 1811, when the first domiciliary was opened by the federal government. State veterans homes provided medical and hospital treatment for indigent and disabled veterans of the Civil War, Indian Wars, Spanish-American War, and the Mexican Border period. Programs of disability compensation, insurance and vocational rehabilitation were in place in 1917, when the U.S. entered World War I. In 1930, The Veterans Administration was created to coordinate veterans benefits for the government. After World War II, huge new benefits packages were created for the veteran population, including the GI Bill. Additional veterans assistance acts were passed for veterans of the Korean War and the Vietnam War and the conflicts to follow.

Over the next several decades, as the federal deficit grew and funds for veterans programs became limited, the Veterans Administration began to tighten the eligibility rules for access to veterans health care. By the time of the inception of the Department of Veterans Affairs as a cabinet department in 1989, hundreds of thousands of veterans had been shut out of the VA health care system. The system had become budget driven rather than needs driven, and veterans began to fall through the bureaucratic cracks. A "means test," which categorized veterans by their net worth rather than their degree of disability or sickness, further blocked access to the system for many sick veterans. Veterans with non-service connected disabilities and a modest income found it almost impossible to obtain health care in the VA system. Eligibility rules became more and more convoluted, raising the barriers to health care. In 1990, the Omnibus Budget Reconciliation Act further tightened restrictions. An eligibility reform package submitted to the Office of Management and Budget as an addendum to the FY 1993 VA budget submission, would have severely damaged the system if it had been approved. Veterans have been excluded in such numbers as to create a number of empty beds which led the Department to propose opening the VHA to non-veterans under the guise of boosting finances by accepting the reimbursement funds of these non-veterans. The motives of the Administration and the role or dedication of VA officials as veterans advocates could certainly come into question at this juncture.

As a result of these impingements on veterans health benefits, The American Legion submits this broad proposal to aid the Department of Veterans Affairs to re institute and preserve the health care benefits which were so rightly earned in the defense of this great nation and to preserve and maintain the Veterans Health Administration as a source of quality health care for veterans.

"The Veterans Administration, now the Department of Veterans Affairs, was created to act as an advocate for the veteran entitled to benefits. That role must never change!"

ENTITLEMENT vs. ELIGIBILITY IN VETERANS HEALTH CARE

Each yearly round of budget negotiations or new program initiative appears to bring with it a change in the eligibility of veterans to receive health care in the Department of Veterans Affairs health care system. At one time, all a veteran had to produce was a discharge certificate to be considered for treatment at a VA health care facility. Now, there is a convoluted system of eligibility requirements which vary by the type of treatment requested, in which war the veteran served, whether or not an illness or disability is service-connected, how much money he or she makes, how much property or investments may be in his or her name and last, but not least, the treatment resources available at the local, regional or national level.

Certain treatment availability is based in legal entitlement to care. Over time, the eligibility criteria went from a form of *carte blanche* system to one using categorical and sub-categorical terms such as discretionary, mandated , A, B, C, sub A, sub B, may, shall and "resource availability" until a veteran throws up his or her hands in confusion or frustration and either seeks treatment elsewhere or, in a much worse situation, goes without needed medical care. Sometimes it appears that those adjudicating access to care cannot be sure who is eligible and who is not. There are even different eligibility criteria for farmers and ranchers. This quagmire of eligibility criteria clearly does several things. It limits access to medical care to many veterans who may have nowhere else to turn for their care, and it proves that health care availability for deserving veterans is based on resource availability not medical need.

The American Legion proposes that all veterans with service-connected disability should have access to whatever modality of medical treatment they require regardless of whether the treatment requested is for an illness, disease or injury related to that disability. This access would be for all service-connected veterans regardless of the adjudicated percentage of disability. In addition to service-connected veterans, former prisoners of war, those exposed to herbicides or ionizing radiation, those receiving VA pension, veterans of specific wars/conflicts and those eligible for Medicaid, must receive care without further eligibility assessment. Any veteran requiring medical care for a non-service-connected disability or illness who has third-party insurance, **including Medicare and other federally administered health care programs**, would receive care which would be reimbursed by that third-party payer with no co-payments or deductibles incurred. Uninsured veterans would receive care without charge or for a charge based on their ability to pay. Non-service connected veterans who have adequate financial resources will be allowed to purchase VA medical care should they desire to be treated in a Department of Veterans Affairs medical facility. Any veteran who suffers a catastrophic illness or injury, the cost of care for which would render him or her financially destitute, would receive care in the VA without charge.

"The nightmare-ish maze of eligibility criteria for care in the VHA must be simplified before any other changes can occur to better VA health care delivery."

THE SPECTRUM OF VA HEALTH SERVICES DELIVERY

The Veterans Health Administration of the Department of Veterans Affairs has at its command one of the widest arrays of service

delivery modalities in the world. These services include acute inpatient care, ambulatory care in several formats, intermediate care, long term care and many specialized programs on both an inpatient and outpatient basis. Access to this array of services is presently restricted by the eligibility criteria discussed earlier. In addition, VA health care delivery must be based upon a "wellness" model and not be predicated upon the user becoming ill and thus requiring acute care before being eligible to obtain care in the VA system.

In order to provide comprehensive holistic care to veterans, the VA must make each and all of the health care services available in a continuum of care to every veteran who demonstrates a need for such services. Each of the services should be available, based on the individuals' medical need as determined by the professional health care or social services provider. Once a veteran has been determined to be in need of any of the offered health care services, he or she must have the capability of being transferred among the services as required for good medical care, guided by only one criterion . . . the fact that there exists **entitlement** for VA health care. It is important to note that there must be a determined need for each and any of the services offered as decided by a health care or social services delivery specialist. Transfer from one type of care or delivery of care can not be determined upon whim but must be based on sound medical or social need.

In simpler terms, once a veteran has been determined to have a need for care in the VA, he or she must have access to any method of delivery of that care which would be most advantageous to medical well-being while maintaining elements of a quality life. For example, to "banish" a veteran requiring long term care to a VA nursing home far away from friends and family would not be acceptable if he or she could receive the same quality and degree of care in a contract community nursing home or in a hospital-based adult day care program, close to friends, family and familiar surroundings. The health care delivery approach should never create an undue hardship upon the veteran, the family, or the health care provider.

The full spectrum of veterans' health care must include preventive health care as well as all the traditional delivery methods up to and including respite and hospice care.

"The veteran must be assured that the particular type of needed medical care can be delivered by the VA without undue hardship such as extensive travel or expense to the veteran. Otherwise, the VA should contract with local health care institutions to provide such care."

AVAILABILITY , ACCESSIBILITY AND ACCEPTABILITY OF VA HEALTH CARE

Aside from cost and quality, three additional elements required for optimal delivery of health care are availability, accessibility and acceptability. Our definitions of these important aspects of health care delivery are:

Availability: The presumption that a particular form of health care delivery is such that a veteran can avail him/herself of that care. The care must be reachable and usable. It would be senseless to have a certain form of specialized health care which few of the veterans in the particular VAMC catchment area would require. In the converse, the failure of the VA to provide a

form of care which is appropriate for their particular veteran population is unconscionable, particularly if the failure to provide is resource based. The VA, and in particular, the local VAMC administration, have a duty to provide care for which a need is demonstrated or to contract that care to a community provider while maintaining full responsibility for the treatment outcome and the quality of such contracted care. There should never be an insinuation that a veteran should go without care because of requirement for travel.

Accessibility: Medical care facilities must be situated in such a locale wherein the services are accessible to the veteran patient without undue hardship. Public transportation facilities should be available or van service provided to VAMCs which are in a remote area. Travel times over two hours for inpatient care or over one hour for ambulatory care are generally not tolerable. Care should be taken in the development of service areas to provide VA medical services that are appropriate for the demographic mix and density of veteran populations.

Acceptability: The quality of care and that of the physical plant and environment, as well as the attitude, qualifications, and mix of care-givers should be as good as or exceed those of area private sector health care providers. Some consideration should be given to the mores, folkways and ethnicity of the regional populace. At no time should the Veterans Health Administration subrogate or abrogate their responsibility to provide quality medical care for veterans by merging with other health care provider systems whose mission is not primarily one of health care to veterans.

THE AGING VETERAN IN THE VA HEALTH CARE SYSTEM

Over the next two decades, barring any conflict, the veteran population in the United States is expected to decrease from about 27,000,000 to slightly more than 20,000,000. However, the number of veterans over the age of 75 will increase 193%. Currently, only one in ten veterans using the VA health care system is at least 75 years of age. This figure will increase by 230% by the year 2010 to approximately 6.2 million. It is clear that the VA must prepare for this increase in numbers of aging veteran patients since these patients will also be sicker and poorer.

It is imperative that the aging veteran patient not be considered in the context of requiring only inpatient long-term care. Aging populations historically consume acute care health resources commensurate with their aging. The provision of long-term or extended care beds will be required to increase. However, not all these patients will be treated in the nursing home setting. Acute care beds, geriatric ambulatory care capabilities and such services as adult day care and domiciliary care will have to be adjusted as the veteran population changes. Provision will have to be made for specialized treatment such as that required for Alzheimer's disease and other diseases of aging. The social aspects of health care will have to be considered as well as such modalities as home health care and respite care.

While planning for the aging patient , it should be kept in mind that there will still be approximately 2 million veterans looking to the VA for their health care needs, that many long term beds are occupied by younger patients with chronic or debilitating diseases or disabilities, and that the VA health care system still must be available as a back-up contingency system for the Department of Defense. All of these variables will have to be considered in order to facilitate the health care needs of the aging veteran.

"Alternatives to institutional long term care can be less expensive and more appropriate for some patients."

PLANNING FOR THE FUTURE OF VA HEALTH CARE

The American Legion believes that the development of a comprehensive planning model for health care delivery by the VA is essential and the key to its future viability in a changing atmosphere regarding the US. health care delivery system as a whole. Both the VA's National Health Care Plan and the recommendations of the Commission on the Future Structure of Veterans Health Care offer some major and almost revolutionary changes which, if carried out , will assure guidance for the future. Should national health care reform occur in the near future, the Veterans Health Administration must survive as a separate entity designed to provide the unique health care required by our veteran population.

Our nation's veterans should be the foundation for planning for the future. The mix and density of this population must be a determining factor in the location, size, mission and type of VA health care facilities. Presently, there seems to be a maldistribution of the existing health care resources both geographically and in regard to mission. Some areas of the US. are virtually barren of VA health care facilities while others have duplicative or overlapping services. For example, certain large metropolitan areas have several VAMCs with tertiary care missions while in other areas of the country, veterans must travel hundreds of miles to receive deserved health care in proper setting. Mission changes will be required in some instances to assure care in the proper health care settings such as acute, ambulatory, community or extended care. Such changes should be timely but not precipitous.

The Veterans Health Administration has indicated that it intends to convert a large number of acute care beds to long term care beds because of the anticipated aging veteran population increase. The VA should keep in mind that the aging patient also requires a great deal of acute health care as well and that such care must be readily available locally to those patients.

In addition, not all long-term health care resources are consumed by older individuals. Young veteran patients with catastrophic disabilities and chronic illnesses such as Acquired Immune Deficiency Syndrome, can occupy many long-term care beds. Also, the VA/DoD Contingency mission to provide care in case of a national emergency impacts upon the number of acute care beds which must be available. The utilization of alternative delivery methods of long-term care should be increased. Expanded use of adult day care, home health care and community nursing home care is essential to maintain the delicate balance required in this long term planning.

The private sector health care industry has undergone a revolutionary change in the way it delivers medical care, particularly in the area of surgical procedures. Some health care institutions perform 60% or more of their surgical caseload in the ambulatory setting. This has been accomplished by utilization of refined anesthesia and procedure selection techniques, improved patient preparation and education and a rethinking of post-operative care requirements by the surgical staff. VAMCs have been reluctant to undertake massive ambulatory surgical programs for several reasons. The primary reason is the concern for post-operative oversight and patient safety by the surgical and nursing staff. Many of these patients do not have the proper support

systems at home or they reside far from the medical center which create care problems post-operatively. The VA must overcome this hurdle by developing plans to accommodate these veteran patients in an ambulatory setting until it is medically judicious to send them to their homes. Many private sector medical centers and military hospitals have solved this vexing problem by providing hotel/motel type or other alternative care facilities to house ambulatory surgery patients in their surgical preparation stages and their immediate post-operative period. These facilities can be operated by the facility or contracted to community intermediaries.

The predicted diminution in ambulatory care volume could be viewed as a "self-fulfilling prophecy" should the VA fail to be creative in the care of ambulatory patients. In addition, the VHA is not presently geared for large volume ambulatory surgical caseloads requiring the diversion of equipment, staff and space. Eligibility for inpatient care could be expanded if the beds occupied unnecessarily by surgical patients not requiring inpatient care could be reassigned. If the VHA truly intends to pursue the expansion of ambulatory care, a review of practices surrounding this option and the resources which will be required had better soon be undertaken.

It is important to reiterate, at this point, that The American Legion will not support the merger of the VA health care system with any other health care delivery system, public or private. We would, however, support the sharing of resources to improve and facilitate quality and cost-efficient health care for veterans. In addition, the VA must maintain control and legal liability over the delivery and the quality of health care rendered under any contract or sharing agreement.

FINANCING ALTERNATIVES FOR VA HEALTH CARE

As the federal deficit continues to escalate and the cost of rendering health care becomes a larger and larger portion of our national expenditures, it becomes increasingly difficult for the Administration to provide adequate funding for the VA's health care facilities, services, research and construction. VHA, the nation's largest health care delivery system, has been seriously underfunded for years. The nation's health care consumer price index hovers around 12% per year while the general inflation rate stays about 3% per year. The 1993 budget submission for veterans health care shows an increase of only 6% or $955 million above current levels. This increase will not fund the VHA at current service levels.

An additional $1 billion, as recommended by The American Legion, would allow the VA to play "catch up," but next year the same dilemma would reappear. As a survival tactic, the VA has reduced certain health care benefits and programs and has imposed co-payments upon the veterans receiving care. However, most disturbing are the changes in eligibility which the VA has imposed. These changes have been a barrier to access to medical care for thousands of veterans. Now, the VA is recommending even tighter eligibility restrictions. Continued imposition of access barriers in the name of cost-cutting must cease.

The American Legion clearly understands that economic uncertainties have created budgetary chaos at all levels of government. These uncertainties offer compelling reasons for planners to seek opportunities which offer the greatest return on the investment of taxpayer dollars. Increased fiscal support for the Veterans Affairs health care delivery system presents such an opportunity.

A substantial portion of the VA's patient caseload consists of veterans who are eligible for other federally funded health care benefits such as

Medicare, Medicaid, Indian Health Service benefits, CHAMPUS and CHAMPVA. Many of these and other patients have some form of third-party payer coverage such as that offered by Blue Cross-Blue Shield and a multitude of private insurance vendors and Health Maintenance Organizations. The VA should be allowed to be reimbursed for medical care from any of these programs.

The Veterans Health Administration now has legal authority to be reimbursed for treatment of veterans' non-service-connected disabilities and illnesses from third-party payers but not from federally funded programs like Medicare and the federal portion of Medicaid. The argument for not collecting these dollars is much less compelling than that for collecting the funds. Programs such as Medicare and Medicaid are third-party payers in the true sense of the words. They reimburse a health care provider for services rendered as a function of costs incurred by that health care provider as a result, and as compensation for, the delivery of those services. The argument that such reimbursement would just move money from one federal pocket to another or does not withstand any test since veterans' health care is an **eligibility** issue while Medicare is a Social Security **entitlement** issue. In addition, the funds appropriated by Congress are predicated upon the existing veteran caseload in the VA. Any expansion of the patient population to include Medicare-eligible discretionary veterans, which should be the targeted population, cannot be considered as a portion of the population already funded by appropriation. This a **new** population of patients bringing with it added cost of care. Therefore, collection of reimbursing funds from Medicare or any other Federally-funded program should be considered as payment for the added cost of caring for these new populations.

"The Department of Veterans affairs has been subsidizing the Social Security system, particularly Medicare, to the tune of about two billion dollars per year through the care of Medicare-eligible veterans without compensation from Medicare."

In other words, the argument put forth by opponents of Medicare payment to the VA, is that compensating the VA for treatment rendered would be a form of "double funding." That is, that the VA is funded to care for veterans so Medicare reimbursement would amount to paying twice for the same care.....**Not so.** Medicare is an entitlement program funded, in part, by premiums, deductibles and co-payments. Most people over 65 years of age are entitled to enroll in the Medicare program. Where they receive their health care is irrelevant as long as the provider is Medicare approved. The VA health care system, with a population of the oldest and sickest, depends upon an annual budgetary appropriation from Congress and is at the mercy of other agency program requests and the general fiscal climate at the time of appropriation.

Several things must happen for the Veterans Health Administration to have stable and appropriate funding. First, VA health care must be considered an **entitlement** for service-connected care The percentage of service disability should not be a factor. This will enable VA to have a base population on which to plan its expenditures and, thence, its budget requests. Second, Congress must begin to include

appropriated funding of any new health care programs which the VA is expected to carry out. Third, the Veterans Health Administration should be allowed to bill third-party insurers, including federally funded programs, such as Medicare and the federal portion of Medicaid in order to fund care not covered by appropriated funds. These federal programs have been getting what amounts to a free subsidization from VA.

In addition, the funds collected for services rendered must revert back to VA with a major portion credited to the Veterans Affairs Medical Center which provided the care. The remainder of the funds should be used by the VA to finance underfunded programs and equipment. Presently, monies collected for care rendered are credited to the U.S.Treasury's general fund to be reallocated to other agencies. This maneuver flies in the face of basic, sound accounting practices.

The question also arises as to how to process a veteran who is not service-connected but wishes to be treated at a VA medical center and is willing to pay for his/her own care A mechanism should be put in place whereby this veteran can be treated and can be billed for the entire cost of the medical care, with rates predicated upon those charged a third-party payer and the veterans ability to pay, even though he/she has no eligibility or entitlement.
Any veteran who is uninsurable should receive treatment in the VA

ACHIEVING, MEASURING AND MAINTAINING QUALITY

Quality of patient care must be the overriding issue in any health care delivery system, public or private. It is the very premise for the existence of such systems and every attempt at every level of care must be made to avoid any deterioration, or the perception of deterioration, of this essential element of patient care. Problems may exist in other elements such as accessibility, acceptability and availability of care, but any evidence of a quality care delivery problem creates a totally untenable situation.

Methods to measure quality are as varied as the medical care they evaluate. Frequently, the perception of poor quality in an institution comes from one or two episodes of publicized questionable patient care. Medical care is an art , not a science. Therefore, an isolated incident of questionable care cannot be made a blanket indicator of poor care. The measurement of quality is an ongoing, never ending process involving the monitoring of care, reporting of adverse reactions and accidents, objective evaluation of care-givers, trending, adherence to proper policy and procedure and a myriad of other techniques. There must be devices in place to monitor compliance with federal, state and local regulations. Regular evaluation by disciplines outside of the organization must be in place to add to the objectivity of the process.

The Veterans Health Administration has a number of programs designed to evaluate, promote and assure quality medical care. Each of these can function independently but are an integral portion of an overall system of quality evaluation. Creation of the Quality Management Institute and the Office of the Medical Inspector as well as the External Peer Review Program and the Continuing Quality Improvement program have been periodic additions to the VA's quality armamentarium. Compliance with the advisement of the Joint Commission on the Accreditation of Health Care Organizations can evaluate the ongoing quality process but cannot be predictors of quality of patient care outcomes and should not be deemed assurances of quality

The utilization of the National Practitioner Data

Bank and implementation of the local credentialing and privileging mechanisms as tools to evaluate the experience and education of medical practitioners are certainly adjuncts to the quality process.

The Quality Management Reference Guide and the Quality Improvement Checklist are fine tools in the process of quality measurement but cannot be viewed as the last word in clinical quality review. **Consistently high levels of success without complications in clinical care outcomes are a much more precise measurement of the quality of that care.** In addition, the ability to hire and keep quality health care professionals is imperative. There must also be ongoing evaluation of equipment, technology and the management process.

"The American Legion Field Service continues to examine and observe VA health care with a focus on quality . "

The keys to successful evaluation of quality care are several. The system of quality measurement cannot fall prey to the budget ax; the quality process itself must be evaluated regularly as delivery methods advance and change; and there must be dedication on the part of practitioners, management, and the administration to maintain the impetus to deliver quality care.

The American Legion advocates and supports quality medical care for veterans and endorses adequate funding to maintain quality and quality measurement systems.

THE ROLE OF PROFESSIONAL EDUCATION IN THE VHA

A synergistic relationship exists between the Veterans Health Administration and the colleges and universities with which it is affiliated. This mutually beneficial relationship helps deliver improved patient care and technologies at the medical center level in return for the availability of a diversified patient population which offers tremendous learning opportunities for resident physicians, fellows, medical students, nursing students, and students of various allied medical professions. The presence of educators and student health care professionals in the clinical arena also acts as a stimulus to VA staff to utilize up-to-date treatment modalities and technologies, perhaps as a response to the challenge created by such presence.

Several other benefits accrue from the affiliation relationship as well. Resident physicians and fellows augment the VA staff in maintaining coverage in clinical areas. Medical students and nursing students, by their mere presence and eagerness to learn, make the work of the nursing unit personnel less burdensome. University-based technology such as magnetic resonance imagers, if in proximity to the VAMC, can be used to serve the veteran patient population. Conversely, university hospital patients can have access to technologies and services which the VAMC may provide and are not available in the university center. These sharing relationships are reimbursable in-kind or by transfer of funds which can be advantageous to both entities.

In the big picture, these affiliations assist the VAMC in supporting and maintaining its assigned mission. This is an area in which the VA must exercise caution. It must be clear that the educational mission of the affiliate and the mission of the medical center coincide. Problems

in patient care may result when either institution tries to realign its mission to maintain the affiliation.

Another "plus" generated by professional school affiliations is in the area of medical and prosthetic research. VA based researchers may have an opportunity to utilize university research facilities while university researchers have an expanded patient population in which to carry out research protocols. VA research has long been known to benefit the non-veteran population as well as veterans as demonstrated by the universally utilized "Seattle Foot" prosthesis.

The American Legion vigorously supports educational affiliations which improve patient care as well as medical education and research.

"Affiliations between the VA and health care educational institutions are capable of creating 'win-win' situations for all concerned."

WOMEN'S HEALTH SERVICES IN THE VA

The VA estimates that there will be nearly 1 3 million women veterans in the US by the year 2000. The American Legion is dedicated to the assurance that these women, who valiantly served their country, will receive quality VA medical care which is appropriate to their gender Availability of services which are unique to the female patient and such amenities as privacy are of major concern

The VA health care delivery system must stand ready to deliver services to the woman veteran without undue hardship to the patient in an atmosphere conducive to patient privacy and, where possible, on a hospital unit wherein other female patients are present. All services which are unique to the female population, including but not limited to, such services as gynecology and gynecological surgery, mammography, Papanicolaou testing, sexual abuse/rape treatment and counseling as well as all other appropriate services of the medical center, must be readily available on site or through referral, contract services or sharing agreements.

Each VA Medical Center and regional office must have a Women Veterans' Coordinator to serve as an advocate for women veterans and to facilitate their entry into the VA system. Women veterans' outreach programs must be utilized nationally and in the specific catchment area to assure that these veterans are aware of the availability of the benefits and services obtainable.

A SUMMARY OF AMERICAN LEGION PROPOSALS FOR VETERANS HEALTH CARE

ELIGIBILITY AND ENTITLEMENT

* **VA health care should be considered an *entitlement* for service-connected care.**

* **The degree of service-connected disability should not be a factor in entitlement to care in the VA.**

* **All veterans with service-connected disabilities have access to a full spectrum of health care services including, but not limited to,**
preventive care, long term care, acute care, ambulatory care, specialized

care, respite care and hospice care.

* Once a veteran has been determined to have a need for care in the VA, he or she must have access to the full spectrum of health care regardless of whether the illness or injury is service-connected.

* There should be only two classifications of veterans for VA health care ; those that are service-connected and those that are non-service-connected.

PAYMENT AND REIMBURSEMENT

* Any veteran without service-connected disabilities should have access to VA health care, with payment by a third party payer.

* Medicare, Medicaid and other federally funded health care financing systems must be considered third-party payers and be expected to reimburse the VA for care provided to non-service-connected veterans.

* Funds collected for medical services rendered must revert to the VA or, more appropriately, the VAMC which delivered the care, not to the general fund of the U.S.Treasury.

* Non-service-connected veterans not entitled to VA care under this proposal should be allowed to receive medical care in the VA for a charge based upon the veterans' ability to pay.

* No veteran will pay deductibles or co-payments in conjunction with care received as a result of entitlement or for care reimbursed.

* Any veteran who suffers a catastrophic illness or injury, payment for which would render him/her destitute, or any veterans proven to be uninsurable, will receive care from the VA without charge.

DELIVERY OF CARE

* VA health care delivery must include preventive health care so that a veteran does not have to become ill to receive care.

* The VA and, in particular, the local VAMC have a duty to provide appropriate care for which a need is demonstrated or to contract for that care with a community provider.

* The VA should maintain full ethical and legal responsibility for treatment outcomes and the quality of contracted care.

* No veteran shall go without needed care because of a requirement for travel by the beneficiary.

* VA medical facilities must be situated in areas wherein services are

accessible to the veteran patient without undue hardship. Service areas should be developed to provide VA medical services which are appropriate for the demographic mix and density of veteran populations.

* The mix and density of the veteran populations must be determining factors in the location, size, mission and type of VA health care facility.

* VA health care must be of a form which is acceptable to the user with consideration for the customs and ethnicity of the veteran patient.

* Gender-specific health care must be provided for women veterans with the same eligibility and availability as that afforded to male veterans.

* The entire spectrum of care must be available to older veterans. Care for the aging patient must not be considered in the context of long-term care only.

* Delivery of care in the ambulatory setting shall be a prime consideration of the VA system. Facilities for temporary housing for ambulatory patients must be pursued.

QUALITY

* The quality of patient care must be the overriding issue in any health care system, public or private.

* The measurement of quality must be an on-going, never-ending process. Policies and procedures must be in place at all times to monitor quality of care within the VA health care system.

* Accreditation surveys by outside agencies can evaluate the ongoing quality process, but cannot be a predictor of the quality of patient care outcomes and should not be deemed an assurance of quality.

* The American Legion Field Service will continue to examine and observe VA health care with a focus on quality.

EDUCATION

* The American Legion vigorously supports the concept of educational affiliations between the VA and professional medically-related educational institutions, which improve patient care as well as medical education and research.

MISSION

* The VA must continue to be the source of the unique health care which the veteran population requires.

* At no time will VA abrogate or subrogate its responsibility to provide

quality health care for veterans by merging with other health care provider systems.

NATIONAL HEALTH CARE REFORM

* The American Legion adamantly opposes any national health care reform which would abolish or diminish the role of the VA health care system in the care of veterans, education or research.

* A properly funded and managed VA health care system might well serve as a model health care delivery system predicated on an equitable balance of entitlement and eligibility for access, funded by a combination of public and private monies and available on the basis of health care need rather than resource availability or the financial status of the veteran applicant.

RESPONSES OF DAVID W. GORMAN
Assistant National Legislative
Director for Medical Affairs
TO QUESTIONS SUBMITTED BY
THE HONORABLE LANE EVANS
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs

Veterans' Access to VA Outpatient Care and Related Issues

1.) What criteria should be used to judge VA eligibility reform proposals?

The absolute, critical need demanding eligibility reform recognizes the current, fragmented set of rules, regulations and policies which creates an environment that obstructs the ability to provide timely, quality and efficient health care services to veterans. Simply stated, VA is required to perform in a manner that can constitute bad medicine and bad economics.

In our view, any eligibility reform proposal must be judged on the basis of how it treats veterans, philosophically and, pragmatically, the manner in which veterans will be assured their health care needs are met in a holistic manner. In other words, any eligibility reform proposal must do what is right for veterans and not what is only right for VA as a system.

A bench mark for any proposal should, we believe, consist of three basic components:

* Access to care - consisting of a "core" group of veterans to which care must be provided and a "non-core" group to which care may be provided;

* Scope of care - the range of health care services that will be provided and would constitute a "full continuum of care;"

* Funding of care - to include a continuation of the appropriation process, as well as VA's ability to seek and retain reimbursements from responsible third-party payers, including Medicare.

2.) Please identify the changes in VA eligibility currently recommended by your organization.

In order to fully respond to this question, the attached DAV Health Care Plan, Legislative Initiative, provides a comprehensive statement as to the DAV's recommendations.

SECTION BY SECTION ANALYSIS OF PROPOSED "AMERICAN VETERANS' HEALTH CARE REFORM ACT OF 1992."

PURPOSE: This is a bill to guarantee comprehensive health care services to veterans and their families by ensuring entitlement and eligibility to a wide array of health care services, to make greater resources and funding available for the delivery of such services, and for other purposes.

SECTION 1. SHORT TITLE; REFERENCE TO ACT.

- Establishes that the legislation will be referred to as the "American Veterans' Health Care Reform Act of 1992." The bill would primarily amend Chapter 17 of Title 38 of the United States Code.

SECTION 2. FINDINGS.

- Recognizes eight basic findings relative to veterans' health care on which the Act is premised and/or which it is intended to remedy. These findings essentially focus on three areas of consideration:

  1. Veterans should be afforded health care services by the VA because of their service to the Nation and the concomitant implicit guarantee that they will be able to access and receive that health care.

  2. Not withstanding that promise, the veterans' health care system is inadequate to meet their needs. Services are restricted without appropriate consideration of medical need or currency and funding of the system is significantly deficient.

  3. There is a need for reforms to the veterans' health care system that will fulfill the Nation's promise to them by providing comprehensive health care services that are attendant to the current and predicted demographic and geographic patterns of veterans. In establishing these reforms the valuable role of the veterans' health care system in national health care reform must be considered.

SECTION 3. ACCESS TO COMPREHENSIVE HEALTH CARE FOR VETERANS AND THEIR SURVIVORS AND DEPENDENTS.

- Categories of Veterans

  - *Core-Entitled Veterans* - including all service-connected veterans, certain low income veterans, former prisoners of war, and additional limited categories of veterans.

  - *Other Eligible Veterans (Non-Core Entitled Veterans)* - including all other veterans not part of the core-entitled category the care of whom is established as discretionary.

- Access and Services

  - Core-entitled veterans shall be entitled to the full continuum of medically-necessary health care provided by/through the VA. This would include, without limitation: inpatient, outpatient, nursing home care (including adult day care), domiciliary care, home health services, respite care, collateral health care and dental care services, readjustment counseling, the provision of therapeutic and rehabilitative devices, seeing eye dogs, and the repair of prosthetic and other appliances, alcohol and drug treatment, and necessary medications.

  - Other non-core entitled veterans would be eligible for all services, at the discretion of the Secretary, without statutorily prescribed limitations, but with the ability to offset the cost of the care received.

  - Readjustment counseling services would be provided without regard to the period of active duty service.

SECTION 4. PREVENTIVE HEALTH CARE.

- Adds a new section formally establishing that preventive health care services would be among the services available to veterans. These services are essential to a comprehensive health care system and can be expected to substantially reduce the longer range costs of health care to veterans and improve their quality of life. Further, service-connected conditions (e.g., amputations), and life-style and genetic factors particularly prevalent among the veteran population (e.g., smoking rates, hypertension rates) suggest the need for these services to be readily available as an entitlement for the core-entitled veterans and contingent on ability to offset cost for non-core entitled veterans.

- The full range of screening, treatment, and educational services would be available and most of these services are delineated in this section, including smoking cessation services, hypertension and colo-rectal and prostate screening, nutritional education, and immunizations.

SECTION 5. HEALTH SERVICES FOR NON-CORE ENTITLED VETERANS AND OTHER ELIGIBLE INDIVIDUALS.

- Adds a new section that would require the VA to put into continuing effect a managed care plan for the delivery of health care services to any non-core entitled veteran and to the survivors and dependents of any veteran. The plan would have to be in effect within 2 years of enactment of the legislation.

- Provides that the VA offer various packages reflecting different combinations of services and ranges of premiums that are structured so as to be affordable to potential purchasers. In order to provide an opportunity to constituent groups to consider the degree of the "affordability" the Secretary would determine the premiums by regulation.

SECTION 6. PAYMENT FOR SERVICES.

- Adds a new section that prescribes the methods of payment that could be used to offset the costs of services to non-core entitled veterans and to survivors and dependents of any veteran.

- Methods of payment would include:

  - Direct out-of-pocket payment;
  - Medicare reimbursement;
  - Medicaid reimbursement;
  - Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) reimbursement;
  - VA Managed Care Plan fund;
  - Private health insurance reimbursement;
  - Any combination of these.

SECTION 7. APPROPRIATIONS; COST RECOVERY; AND SEQUESTRATION.

- Establishes that funds for the provision of health care services to core-entitled veterans, inclusive of administrative costs associated with that care, would be appropriated as a non-discretionary entitlement exempt from sequestration, beginning in Fiscal Year 1993.

- Further, provides that the mandatory, entitlement appropriation would take into account costs associated with quality management and assurance functions.

- Administrative costs related to the non-mandatory services provided by VA to/for other than the core-entitled veterans would be separately appropriated and separately accounted for and stated in the President's budget requests.

- Establishes the authority of VA to collect reimbursements from Medicare and Medicaid for the treatment of veterans, survivors, and dependents eligible under those programs.

- Provides that the VA would have the authority to use any funds deposited in the Medical Care Cost Recovery Fund to provide health care benefits to eligible persons, to operate the VA health care system, and to enhance the quality of care and the delivery systems providing health care to veterans.

- The President's budget requests for the VA would have to be developed without consideration of the collected/reimbursed amounts deposited into the Medical Care Cost Recovery Fund.

SECTION 8. ANNUAL REPORTS.

- Requires the VA to report to the House and Senate Veterans' Affairs Committees by January 15 of each fiscal year on the impact of the effected reforms. Specifically, the report would include:

    - Cost information and cost changes between the reformed system and the system of health care delivery prior to reforms;

    - Current and former information on the demographics of veterans, and of their access and use of the health care system;

    - Findings and conclusions as to effectiveness of reforms in terms of access, medical advantages, and cost;

    - Plans for legislative or regulatory actions necessary to the continued effectuation of the reforms.

- Congressionally-chartered veterans' organizations would be given the opportunity to provide comments which the VA would consider and include in the reports.

SECTION 9. EFFECTIVE DATE.

- Provides for implementation of most reforms by the beginning of the first fiscal year occurring after enactment.

THE DISABLED AMERICAN VETERANS HEALTH CARE PLAN

Legislative Initiative

INTRODUCTION:

The Disabled American Veterans (DAV) has closely monitored with great interest the activities of the VA Commission on the Future Structure of Veterans Health Care (Commission). The DAV has long recognized the need for improvements to the VA's health care delivery system. The DAV has actively advocated necessary and significant increases to the VA medical care budget. Moreover, the DAV has taken a prominent position in advocating and supporting realistic, necessary and appropriate reforms in veterans' health care in order to guarantee the effective and continuous availability of quality health care that meets the needs of those who have been disabled in military service to the nation.

It has become increasingly apparent to the DAV that the actions taken, heretofore, to improve VA health care delivery, to attempt to equitably provide needed care with insufficient operating funds, and to plan for the future needs of the aging veteran population have been woefully inadequate.

Further, it is only reasonable to consider the needs of the veterans' health care system in the context of the needs of the American health care system. The DAV has closely examined the important role of the VA in delivering health care to disabled veterans, a valued segment of the American population. We have identified the contributions the VA health care system makes; we have weighed those contributions in terms of their impact on the American people as a whole, and, in terms of the responsibility of the nation "...to care for him who shall have borne the battle, and for his widow, and his orphan."

We agree with the Commission that the nation has made a significant "...investment in human and physical resources of VA programs and their unique capabilities." We also agree with their observation that the VA can make important contributions to the wider health care efforts of the nation, but it faces a significant obstacle in that available operating funds have not kept pace with need.

The VA is a national asset in significant financial trouble. We have studied the report and recommendations of the Commission. We have held numerous discussions with health policy and health financing experts, congressional staff, Commissioners and members of the Commission staff, VA and other Administration officials. We are aware of the current activities in VA to respond to the Commission recommendations. The needs of our constituents, America's disabled veterans, and our deliberations and findings, demand that action be taken immediately. This is the DAV's plan of action.

PURPOSE:

To provide a plan that will begin the effort needed to reform and clearly define the statutory provisions that impact access of veterans to needed health care. Further, the plan will define the nature of the comprehensive care required to promote the health and prevent the further disability of the veteran population. This plan provides funding mechanisms and suggests initiatives to promote quality and cost-containment in the provision of health care by VA.

The DAV believes that an independent VA will continue to be an important part of health care in this nation. Ultimately, this plan is intended to ensure that the VA continues to be a system that serves the unique needs of veterans only, while supporting education and research for the good of the country. Through adoption of this plan and the provision of sufficient funding, the VA can meet these needs.

PROPOSAL:

The DAV Health Care Plan has several component areas: access, including general eligibility and core entitlement; the definition of benefit packages and coverage; and, funding, including reimbursement and budgetary considerations.

Section 1 - Veterans' Access to Health Care.

A. **General Eligibility**: All honorably discharged veterans are eligible to receive any health care services provided under the auspices of the Department of Veterans Affairs. This may include treatment by VA providers in VA facilities, or by non-VA providers and non VA facilities as provided for by VA. It is intended that any veteran desiring VA health care may receive such care because he/she is in an entitlement category for which VA is funded to provide care; or, because he/she has the ability to offset costs through reimbursement, or direct payment; or, because he/she has purchased a VA health benefits package.

B. **Core Entitlement:** This entitlement ensures the ability of covered veterans to access the VA health care system, whenever care or treatment is needed. This following groups comprise the core entitled and their entitlement is not to be further limited beyond the described criteria.

(1) Service-Connected Disabled. All veterans determined to be disabled due to military service will be guaranteed full entitlement to all needed health care services.

(2) Low Income. All veterans, without regard to disability rating, whose income does not exceed the current means test threshold level, will be guaranteed full entitlement to all needed health care services.

(3) Special Categories. All former Prisoners of War, all veterans exposed to agent orange/ionizing radiation, all veterans of World War I and the Spanish American War will be guaranteed full entitlement to all needed health care services.

Section 2 - Benefits and Covered Services.

A. **General:** The focus of VA must move from sick care to health care; from the traditional acute care perspective or the disease model to a disability-based model with a comprehensive focus on health promotion and disability and disease prevention and treatment. By working within a framework that focuses on disability rather than disease the concept of health care for veterans will be significantly less constrained. It is the responsibility of the VA as a health care provider to promote health throughout the lives of veterans, to prevent those taken ill from becoming disabled, and to help the disabled to prevent further disability. It is the responsibility of the veteran to work to maintain his/her health. It is the responsibility of both the VA and the veteran to be cost-conscious and to be sure that health care services are not sought or used for equivocal or inappropriate reasons.

B. **Clinical Services:** In providing a full continuum of care to veterans, clinical services must include all inpatient and outpatient services that may be provided in institutional and non-institutional settings, including acute, long-term, mental health, rehabilitative, transitional and palliative, as well as home, day, hospice, respite and domiciliary care, necessary social supports, including homemaker services, meals-on-wheels, and transportation, dental and eyecare, medications and medical supplies, and prosthetic and orthotic devices.

C. **Preventive Services:** These services will include a full range of s treatment and educational programs. Among the included services are: mamm Pap smears, hypertension screening, colorectal and prostate screening proce glaucoma screening, smoking cessation services, and nutrition counseling.

Emphasis is to be placed on the provision of these preventive services so that earlier diagnosis and treatment may be possible and may result in reduced mortality rates and increased quality of life for veteran patients, and may produce savings by averting costs of expensive treatment.

D. **Long Term Care:** Comprehensive health and restorative care including institutional and non-institutional programs and services and necessary social support services. In VA this will include the full scope of interdisciplinary geriatric programming and rehabilitative services, as well as nursing home and domiciliary care.

E. **Coverage of Core Entitled:** All veterans determined to meet the requirements for a core entitlement category will not be precluded from receiving any needed care, support service, supplies, devices, or diagnostic service. It is intended that the full continuum of care will be available for the core entitled, including any and all clinical services, programs, and supplies needed to ensure that a veteran's care is comprehensive and appropriate will be available and provided.

F. **Benefit Packages for Eligible (non-entitled) Veterans:** The VA will have the authority to define a variety of benefit packages varying in scope and cost. Services covered in these benefit packages will range from the full continuum of care described for the core entitled (see E) to a limited package that may exclude long-term care, ancillary services, etc. Eligible veterans may choose a desired benefit package dependent on needs, interest, and ability/willingness to offset cost. Opportunities to change selected coverage will be provided by VA with reasonable frequency and in consideration of significant changes in the veteran's circumstances.

Section 3 - Funding of Veterans' Health Services.

A. **Appropriations:** There will be two separate medical care appropriations. One will be designated for health care provided to veterans in the core entitlement category. This is to be considered an entitlement program. Spending and funding for this program is dependent on how many individuals meet the core entitlement eligibility requirements and the amount and cost of services that are delivered to them. Those strictly administrative expenses within the medical care appropriation will be considereddiscretionary budget items. These administrative expenses will be specifically defined in the President's Budget submission. In order to ensure the ability of VA to provide effective and cost-conscious care, quality management an assurance functions,

including those related to peer review, utilization review, practice standards and their administration and oversight, will not be considered discretionary. Funding appropriated for entitlement categories may not be used to fund functions in discretionary categories.

The other medical care appropriation will be applied to health care for all other eligible veterans. Appropriate budgetary projections for the costs of VA health care provided to the eligible veterans not in the core entitlement categories will be developed in consideration of reasonably expected collections/reimbursements for costs from sources described below. The VA will be entitled to retain any and all funds collected/reimbursed for care provided to these veterans.

B. **Reimbursement:** The VA will be reimbursed for care provided to veterans not in the core entitlement categories who are covered by Medicare, Medicaid, CHAMPUS, and private health insurance, under governing provisions of those programs.

C. **VA Buy-In Options:** VA will develop a variety of options for veterans to buy into various VA health benefit packages. The costs for these options will be based on reasonable fee schedules consistent with reimbursement values developed by and acceptable to Medicare. Costs will also be structured to provide for a veteran to buy a minimal care package for an affordable cost on a sliding scale, considering income levels.

D. **Direct Payment:** Eligible veterans may choose to directly pay out-of-pocket for VA health care services received. VA will have available for information and billing purposes chargeable fees for service, medications, supplies, etc.

E. **Other:** It is expected that all honorably discharged veterans will be eligible for VA health care because they will fall into one of the core entitlement categories or into a reimbursement, payment, or buy-in category. VA may ascertain the appropriate/chosen method of payment for these veterans before care is provided. However, no veteran will be denied care or treatment on the basis of their method of payment.

BACKGROUND INFORMATION

SECTION I - VETERANS' ACCESS TO HEALTH CARE.

A. GENERAL ELIGIBILITY: All honorably discharged veterans are eligible to receive any health care services provided under the auspices of the Department of Veterans Affairs. This may include treatment by VA providers in VA facilities, or by non-VA providers and non VA facilities as provided for by VA. It is intended that any veteran desiring VA health care may receive such care because he/she is in an entitlement category for which VA is funded to provide care; or, because he/she has the ability to offset costs through reimbursement, or direct payment; or, because he/she has purchased a VA health benefits package.

VETERAN POPULATION INFORMATION (000s)				
	1990	% of Total	2010	% of Total
Total Veterans	27,000	--	20,503	-
Under Age 65	19,909	73.7	12,321	60.1
Age 65 or Older	7,091	26.3	8,182	39.9
Vietnam Era	8,295	30.7	7,036	34.3
Service-Connected	3,484	12.9	2,304	11.2
Non-Svc. Connected	23,517	87.1	18,199	88.8
-- Low Inc./Spec.	8,130	30.1	*6,293	30.7
-- All Other NSC	15,387	56.9	*11,910	58.1
Veterans Using VA	2,428	--	2,190	--
Service-Connected	1,135	46.8	1,005	45.9
Non-Svc. Connected	1,293	53.2	1,185	54.1
-- Low Inc./Spec.	1,152	47.4	1,020	46.5
-- All Other NSC	141	5.8	165	7.5

* Estimated based on application of 22.6% reduction (as in total NSC population from 1990 to 2010) to 1990 totals for each category.

Source: VA Data Bases, including Patient Treatment File and material produced by Boston Development Center for Commission; projections by VA Biometrics Division, and Commission.

B. CORE ENTITLEMENT: This entitlement ensures the ability of covered veterans to access the VA health care system, whenever care or treatment is needed. This entitlement will be provided without regard to the individual's disability rating or any other factor, such as income level or other non-VA eligibility for health care, unless specifically provided as an entitlement criteria, e.g., low income.

(1) Service-Connected Disabled. All veterans determined to be disabled due to military service will be guaranteed full entitlement to all needed health care services.

SERVICE-CONNECTED DISABLED VETERANS (000s)		
Disability Rating	Number of Veterans	% of All Veterans
0%	1,300	4.8
10%	878	3.3
20%	358	1.3
30%	306	1.1
40%	180	.7
50%	108	.4
60%	110	.4
70%	64	.2
80%	35	.1
90%	13	.05
100%	132	.5
Total	3,484	12.9

(2) Low Income. All veterans, without regard to disability rating, whose income does not exceed the current means test threshold level will be guaranteed full entitlement to all needed health care services.

- The General Accounting Office has reported that based on the March 1986 Census Bureau's Current Population Survey, it is estimated that **5,104,000 veterans** had incomes and assets below the VA means test threshold levels.

- In Fiscal Year 1990, **1,313,606 veterans** (25%) below the means test threshold for Category A made application for VA health care.

(3) Special Categories. All former Prisoners of War, all veterans exposed to agent orange/ionizing radiation, all veterans of World War I and the Spanish American War will be guaranteed full entitlement to all needed health care services.

- The General Accounting Office has reported the following estimates for the special categories:

Prisoners of War	85,000	(VA data)
World War I	317,000	(Census Bureau data)
Ionizing Radiation	231,000	(GAO est.)
Agent Orange	2,200,000	(Census Bureau data)
TOTAL	2,833,000	

- In Fiscal Year 1990, **389,632 veterans** (14%) in these categories made application for VA health care.

INFORMATION ON PROJECTED POPULATION BY CATEGORY (000s)

	Total Pop.	VA Users	
	1990	1990	2010
Total **ENTITLED** Veterans	11,614	2,287	2,025
Service-Connected	3,484	1,135	1,005
NSC - Low Inc./Spec.	8,130	1,152	1,020
Total **NON-ENTITLED** Veterans	15,387	141	165
Total Veterans	27,001	2,428	2,190

Source: VA Data Bases, including Patient Treatment File and material produced by Boston Development Center for Commission; projections by VA Biometrics Division, and Commission.

SECTION 2 - BENEFITS AND COVERED SERVICES.

A. GENERAL: The focus of VA must move from sick care to health care; from the traditional acute care perspective or the disease model to a disability-based model with a comprehensive focus on health promotion and disability and disease prevention and treatment. By working within a framework that focuses on disability rather than disease the concept of health care for veterans will be significantly less constrained. It is the responsibility of the VA as a health care provider to promote health throughout the lives of veterans, to prevent those taken ill from becoming disabled, and to help the disabled to prevent further disability. It is the responsibility of the veteran to work to maintain his/her health. It is the responsibility of both the VA and the veteran to be cost-conscious and to be sure that health care services are not sought or used for equivocal or inappropriate reasons.

INFORMATION ON THE DISABILITY MODEL

The Institute of Medicine has recently reported on the disability-based model, particularly in terms of its applicability to an elderly population. Most of the concepts can be generalized to the VA population, now and as it continues to age.

The concepts underlying the disability model extend well beyond the restrictive perspective of the acute care, disease model. Unlike disease, the effects of disability are not spatially constrained to organs and tissues of the human body. It is because of this broader view of disability that applications of acute care diagnostic approaches to disability may cause the personal aspects of disablement, and the social manifestations, to be overlooked. The mere recognition and treatment of the physical abnormality associated with the disability is insufficient. Aptly, the IOM suggested the example of the wheelchair-bound mason versus the wheelchair-bound writer. They may have the same cause for being wheelchair-bound, but the manifestations of their disabilities are likely to significantly differ.

In order for "comprehensive care" to be a reality in treating the disabled, the elderly, and any other group at risk for disability, the elements of necessary care, support, and treatment must be broadly viewed. The focus on 'cure' associated with the acute care framework will generally be limiting in the disability arena. The IOM pointed out that application of the disability-model includes the following assessments:

- Limitations on the individual's capacity to live independently and/or to care for him/her self.
- Interference with maintaining/initiating relationships, pursuing career goals, and enjoying leisure activities.
- Existence of barriers to personal autonomy, ranging from such things as inaccessibility of public accommodations to the extent of political empowerment.

Noting the absence of consensus on a classification system that provides a sufficiently broad understanding of disability, the IOM has supported the use of the World Health Organization's (WHO) system, the "International Classification of Impairments, Disabilities and Handicaps." The IOM suggests that this system will serve as an appropriate, descriptive and introductory framework for health care providers to shift their attention toward the provision of truly comprehensive care to patient populations.

It is particularly interesting to consider the application of the disability framework in the assessment of the veteran population and its health care needs. When the concepts of the disability model are applied in the VA, there can be predicted a different perspective about the costs of and services needed to prevent further disability in the veteran population, as well as the appropriate focus of research.

Source: The Second Fifty Years: Promoting Health and Preventing Disability. Institute of Medicine, Division of Health Promotion and Disease Prevention (National Academy Press: Washington, DC), 1990.

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SECTION 3 - FUNDING OF VETERANS' HEALTH SERVICES.

A. APPROPRIATIONS: There will be two separate medical care appropriations. One will be designated for health care provided to veterans in the core entitlement category. This is to be considered an entitlement program. Spending and funding for this program is dependent on how many individuals meet the core entitlement eligibility requirements and the amount and cost of services that are delivered to them. Those strictly administrative expenses within the medical care appropriation will be considered discretionary budget items. These administrative expenses will be specifically defined in the President's Budget submission. In order to ensure the ability of VA to provide effective and cost-conscious care, quality management and assurance functions, including those related to peer review, utilization review, practice standards and their administration and oversight, will not be considered discretionary. Funding appropriated for entitlement categories may not be used to fund functions in discretionary categories.

The other medical care appropriation will be applied to health care for all other eligible veterans. Appropriate budgetary projections for the costs of VA health care provided to the eligible veterans not in the core entitlement categories will be developed in consideration of reasonably expected collections/reimbursements for costs from sources described below. The VA will be entitled to retain any and all funds collected/reimbursed for care provided to these veterans.

INFORMATION REGARDING ENTITLEMENT SPENDING PROGRAMS

Currently, the VA's Fiscal Year 1993 Budget will be determined based on the spending cap set by the Congress for the discretionary domestic programs. However, according to the 1985 Balanced Budget Act, there will be a single discretionary spending category as of Fiscal Year 1994, collapsing defense, international aid and domestic programs. The budget authority spending cap for discretionary programs in fiscal year 1994 will be $510.8 billion. This is about $1 billion less than the total of the budget authorities for the three FY 1993 discretionary categories. Further, absent recognition of VA health care as an entitlement program, that program may be faced with substantive competition with defense funding interests, as well as such international aid as most-favored nation funding efforts.

Adding to the argument to move VA health care spending for the core entitled into the entitlement category is the fact that Medicare is already an entitlement program. It is consistent to argue that since VA is not seeking reimbursement from any sources for the care of the core entitled, the costs of meeting their health care needs should be viewed in the same manner as the costs for providing health care to Medicare beneficiaries. The core entitled receiving treatment through VA, who might otherwise be among Medicare's beneficiaries, would not be drawing on their entitlement under the Medicare system. It is only when VA can afford to provide the full scope of health care to the core entitled that the Medicare program is ensured of few of these individuals drawing on their Medicare entitlements.

It is arguable that when core entitled veterans are not receiving their health care through the VA, then those eligible individuals may be expected to draw on their Medicare entitlement, generally at a higher cost, than the VA care would have cost. Consequently, by funding VA at levels sufficient to ensure quality care of these entitled veterans, a cost avoidance can be projected for Medicare. This would appear to contribute to the overall governmental interest in deficit reduction.

INFORMATION REGARDING EXCLUSION OF ADMINISTRATIVE COSTS FROM ENTITLEMENT CATEGORY.

Drawing on the Medicare experience, one can see where the inclusion of the administrative expenses, particularly those that relate to the costs of utilization review and other quality management and cost-containment practices, in discretionary spending categories is antithetical to the intent of providing cost-effective health care. In the case of Medicare, the funding of its administrative functions has been among the programs competing at a less than successful level in the domestic discretionary category. Analysis suggests that every dollar spent on medical and utilization review in the Medicare program, saves at least five dollars. In Fiscal Year 1991, the administration's budget proposal for Medicare provided for $110.8 million for these reviews in anticipation of them resulting in savings of $760 million.

Source: Physician Payment Review Commission. Annual Report to Congress, 1990 (required by OBRA 1986).

B. Reimbursement: The VA will be reimbursed for care provided to veterans not in the core entitlement categories who are covered by Medicare, Medicaid, CHAMPUS, and private health insurance, under governing provisions of those programs.

INFORMATION REGARDING COSTS OF CARE (See Section on Cost Information for estimates.)

The VA Commission obtained an estimate of future costs of care based on 1990 dollars. This expected cost presumes that there would be no change in the VA health care delivery system. A potential difficulty with this projection, besides the fact that it is only valid for comparison as if it were true in 1990, is that it averages costs across all types of care. Presumably it accounts for users who are provided more than one type of care (e.g., inpatient and outpatient care) by weighting each category.

COST PROJECTION			
	VA Users (000s)		Avg.Annual Cost/User (all svcs.)
	1990	2010	
Service Connected	1,135	1,005	$4,326
NSC-Low Inc./Special	1,152	1,020	$4,326
NSC Other	140	125	$4,326
Other Veterans (Buy-ins)	NA	40	$3,471
TOTAL ANNUAL COST	$10.5 Billion	$9.4 Billion	

If a managed care system were adopted in VA the Commission consultants estimated a possible range of costs from $8.5 billion to $9.4 billion.

Although not included in the draft report, the Commission staff developed a cost projection of $11.653 billion for estimated 2010 workload primarily based on projected changes in bed levels. That estimate assumed:

- 1,018,603 inpatients would be treated.
- 24,324,168 outpatient visits would occur.
- 2,764,110 outpatients would receive care, based on 8.8 average visits per patient.
- Workloads by DRG were adjusted based on having weighted the ages of the projected population in 8 different age categories.
- The administrative workload (included in indirect costs of care) would be reduced by 10% of $102 million.
- Half of the patients with the shortest lengths of stay would be moved from the inpatient to the outpatient category of care.

INFORMATION REGARDING POTENTIAL REIMBURSEMENT (See Section on Cost Information for estimates)

VA has projected collections of up to $720 million by the mid-1990s from private insurers.

The Commission developed an estimate of possibly $3 billion in reimbursements from Medicare. However, it was reported by Commission staff that the estimate was simply based on the number of veterans 65 or older and an average VA per diem cost of care. Given the complexity of the Medicare reimbursement mechanisms, it is unlikely that the Commission's method of estimating would result in a reliable estimate.

For purposes of estimating possibles reimbursement levels, the following assumptions/estimates were used:

- Currently, 87.3% of veterans are believed to have some form of health insurance coverage. It is assumed that this percentage of insured will remain relatively constant.
- It is estimated that 75% of veterans treated by VA (now and in the future) are insured, to some extent (including Medicare and Medicaid).
- A reasonable estimate of insurers' level of reimbursement of costs is 70%.

C. VA BUY-IN OPTIONS: VA will develop a variety of options for veterans to buy into various VA health benefit packages. The costs for these options will be based on reasonable fee schedules consistent with reimbursement values developed by and acceptable to Medicare. Costs will also be structured to provide for a veteran to buy a minimal care package for an affordable cost on a sliding scale, considering income levels.

INFORMATION REGARDING COLLECTIONS FROM 'BUY-IN' PROGRAM

The Commission presumed that the premium structure for a buy-in program would be designed to fully offset the additional costs to VA for providing care to those individuals covered. Based on the data projected for the Commission, it was estimated that VA had the potential of attracting 23,013 to 65,616 veterans into this program; 40,000 were used for estimating purposes. At an average annual cost per user in a managed care program of $3,471 the total annual cost was estimated at $138.8 million for these new users.

Using the premium structure suggested by consultants to the Commission, it was assumed that all 40,000 veterans would purchase the comprehensive service package that would include long term care and other services expected in a full continuum of care. It was further assumed that all 40,000 would opt for the standard Medicare deductible levels. Additionally, the following demographic data were considered:

- 27% of veterans are presently Medicare eligible.
- 46% of VA hospital patients have no dependents.

	Premium Collections from Buy-Ins			
	Prior to Medicare Eligibility (29,200 Total)		Post Medicare Eligibility (10,800 Total)	
	Single	Family	Single	Family
# of Buy-Ins	13,432	15,768	4,968	5,832
Premium/Month	$ 198.70	$ 512.19	$ 430.52	$ 861.03
Monthly Collections	$ 2,668,938	$ 8,076,212	$ 2,138,823	$ 5,021,522
Annual Collections	$32,027,260	$96,914,542	$25,665,879	$ 60,258,322
TOTAL				$214,866,003

MISCELLANEOUS BACKGROUND INFORMATION

MEDICAID

- The Federal match portion of a state's Medicaid funds is determined based on a formula applied to that state's per capita income information. The minimum percentage of the Federal match is 50%. The maximum percentage is 83%. The lower the income level the higher the match rates.

- There are currently 22.5 million Medicaid beneficiaries. However, most of the categories of people and care included under Medicaid would not be there very nature encompass a large portion of veterans. Medicaid places a great deal of emphasis on and is more heavily used by women and children, populations not highly representative of veterans.

- In 1986, 45% of total Medicaid spending provided only 7% of its eligible population with services in nursing facilities or institutions for the mentally ill. Many experts question the advisability of Medicaid being the source of funding for long term care.

ASSUMPTIONS

ASSUMPTION 1 - Data: *Although the methodology, survey instruments, weighting factors, etc., used by the Commission are not generally known, their demographic and socioeconomic data are generally being considered as accurate. Although deviations may be noted when evidenced by other data bases, such as the National Medical Expenditure Survey. However, the conclusions drawn herein based on Commission data may not be consistent with the conclusions drawn by the Commission.*

ASSUMPTION 2 - Costs/Reimbursement: *The Commission's report deals with costs of the recommendations and associated amounts of alternative funding rather generally. It has suggested that VA might expect to collect as much as $3 billion in reimbursements from Medicare. However, given the general nature of the estimating process and the caveats placed by the Commission itself on costing its recommendations, it is assumed that no reliance should be placed on its cost/reimbursement data.*

ASSUMPTION 3 - Market Share: *The following factors suggest that the VA's share of the veteran health care market will be larger by the year 2010, i.e., the number of veterans who will seek and receive care in the VA will increase.*

- Currently approximately 1 in 10 veterans in the country use the VA system for health care.
- Approximately 25% of all Vietnam era veterans' hospital stays and outpatient care is provided by VA, according to the findings of the National Medical Expenditure Survey of 1987 (NMES), conducted by the Agency for Health Care Policy and Research, DHHS.
- The health care needs of these Vietnam veterans can be expected to increase as they grow older. This coupled with their familiarity and apparent confidence in the VA delivery system suggests greater utilization of the VA by this segment of the population in the future.
- Vietnam veterans presently comprise 31% of the veteran population. By the year 2010 it is expected that Vietnam veterans will represent the largest category of veterans by period of service as 34% of the veteran population.
- As all other veterans, not currently using the system, continue to age, their need for health care services, particularly long-term care, and the attractiveness of the VA option for these services, can be expected to increase.

ASSUMPTION 4 - Insured/Medicare Eligible: *The percentage of veterans currently believed to have some form of health insurance coverage (87.3%) will remain relatively constant.*

ASSUMPTION 5 - Attractiveness of VA Long-Term Care: *The conditions under which VA provides long-term care to entitled veterans (i.e., at no cost) will be more attractive than coverage offered by other providers. It is also assumed that VA costs for long-term care for other eligible veterans will be less than other providers in many cases.*

ASSUMPTION 6 - VA Bed Levels and Occupancy: *It is assumed that Commission's projections of bed levels and its goal of an 80% occupancy rate for VA inpatient services can and will be achieved/maintained by VA.*

ASSUMPTION 7 - Unnecessary or Inappropriate VA Care: *Cost containment can and will be achieved to some degree in VA health care by the development and application of practice guidelines, effective provider utilization/peer review, extensive health promotion, and patient education. Some percentage of the total number of veterans who present themselves to the VA for care are not in need of any health care service; this number can be reduced by effective health promotion and patient education efforts. Some percentage of the services provided to VA beneficiaries are of little or no health care value (although not necessarily detrimental or harmful); this number can be reduced by the adoption of effective practice guidelines, provider education, and effective monitoring and analysis of utilization data and physician practice patterns.*

- Studies have suggested that as high as 20%-25% of acute care hospital service or procedures provided to elderly Americans may be used for equivocal or inappropriate reasons.

- Further, there is evidence to also suggest that some services provided to patients who are not paying for those services may not always be medically necessary or may represent excessive services provided to satisfy patient demand without regard to cost effectiveness or medical efficacy.

- In one small review of VA outpatient care provided at four separate VA outpatient clinics, 5% of the patients that presented for treatment were found not to be in need of medical care.

ASSUMPTION 8 - Total Veteran Population: *Total veteran population estimates by the Commission are assumed to be accurate. However, distribution of veterans by age group will significantly change, particularly since more veterans will live longer. The fact that more veterans will enjoy longer lives will not result in an increase in the projected veteran population because the potential for more veterans continuing to live will be offset by decreases in the number of "new" veterans resulting from separations from active duty military.*

- The total veteran population, currently at 27 million, will fall to about 20.5 million by 2010.
- Notably, the number of veterans who are 75 or older will increase from the present 5.5% of the total to 21.4% of the total.
- The survival rates for veterans will increase due to improved access to care, technological advancements, and greater emphasis on health promotion and disease prevention by VA.
- The Commission assumed that separations from the military would remain constant and that since veteran survival rates are already better than the general white population, which is attributed to the health screening/medical requirements at time of entry on active duty, they are not likely to increase greatly.

COST INFORMATION

A. *General*: Every effort has been made to provide cost information that is sufficiently related to the proposal so as to allow a reasonable estimate of the fiscal impact of the proposal, in terms of 1990 dollars. However, there are significant difficulties with the available data. The basic goal of this cost information is to provide the DAV with an indication of the projected cost in current dollars of providing the full continuum of care to core entitled veterans versus basically eligible veterans; or, to project the cost of VA care that will not be reimbursed, under the proposal, by non-VA sources.

Among the most significant difficulties encountered is the reality that current VA cost data do not represent the full continuum of care. Notably, the cost of most preventive health care services is not included; nor are the cost savings that might result from early detection/prevention, resulting from the provision of extensive screening tests, etc. Absent experiential data, gross assumptions have been made to arrive at estimates of these costs.

The initial approach to costing this proposal was to consider the differences in costs of the various groups of veterans who are currently receiving VA care, and who would likely receive care under the proposed conditions. As stated in earlier assumptions, the data used by the Commission, particularly the demographic projections of veterans and veteran users, were considered accurate for this purpose. However, it must be recognized that the eligible categories of veterans under the DAV plan, do not precisely mimic the Commission's categories. Further, the thrust of the cost data available from the Commission was premised on the structuring of the VA system as a managed care system, a premise that does not carry over into the DAV proposal.

In addition to Commission data, VA data, primarily from published sources, were extensively used. It is interesting to note that the various data bases maintained by VA track information in diverse fashions. For example, cost data is sometimes reported by bed section and sometimes reported by broader types of care. It may be that data tables can be constructed by VA to provide information in a manner that would be more helpful to the DAV effort. However, no special computer runs were requested from VA, per DAV instructions. (This information may also be available through the Independent Budget staff who reportedly hold data tapes provided by the VA's Boston Development Center, the location of most budgetary data efforts within VHA).

B. Current Cost Information: To the extent that data were available, Table 1 provides costs by various veteran categories and by type of care for fiscal year 1990.

Table 1 - COSTS BY CATEGORY OF CARE AND ELIGIBILITY

Category of Care and Eligibility Group (% of Total)	*Patients Treated	*Cost Per Patient	Total Cost (000s) (FY90 Obligation)
Inpatient - VAMCs	1,026,159	$6,431	$6,614,926
• Service-Connected (33.6%)	344,664	**6,442	**2,222,615
- SC for NSC Cond. (22.7%) part of SC above	232,758	**6,445	**1,501,588
• Non-Svc Connected (65.8%)	675,071	**6,448	**4,352,621
• Non-Veterans (0.6%)	6,414	**6,615	**39,690
Inpatient - Contract Hosp.	20,968	7,192	157,461
Outpatient Visits	22,602,540	**$128.83	$2,911,889
• VA Only (94.7%)	21,399,342	**128.86	**2,757,559
- Svc-Connected (43.7%)	9,885,926	**128.72	**1,272,495
- NSC (47.3%)	10,683,641	**128.91	**1,377,323
- Non-Veterans (37.0%)	829,775	**129.81	**107,740
• Fee Visits (5.3%)	1,203,198	**128.29	**154,330
Long Term Care	96,696	**$11,898	$1,154,104
• Nursing Home Care (73.5%)	71,026	**14,362	1,019,676
- VA (28.0%)	27,067	24,625	666,523
- Community (29.8%)	28,851	8,452	273,708
- State (15.6%)	15,108	4,957	79,445
• Domiciliary (26.5%)	25,670	**6,575	170,937
- VA (19.5%)	18,895	8,198	154,905
- State (7.0%)	6,775	2,067	16,032

* For Outpatient category this reflects number of visits and cost per visit.

** These costs were constructed; based either on ratio of this portion of population to the total, or on division of actual total cost by number of patients treated. In all cases actual FY 1990 data were used where available.

Source: VA Fiscal Year 1990 Annual Report; Patient Treatment File and Annual Patient Census.

C. Projected Costs

1. Commission consultants developed an average annual cost per user for 2010, based on 1990 dollars, of $4,326. This cost estimate used the Commission's eligibility projections which presumed 2,190,000 veteran users. This is an approximate total cost of $9.5 billion. However, it does not include estimates for preventive care or social support services, and it assumes no change in VA's market share in any category; although it was recognized that an increase in the percentage of users of long term care was probable.

Application of the same per user cost (i.e., $4326), as developed by the Commission consultants, to the projected users by DAV entitlement category is as follows:

Table 2 - PROJECTED COSTS - #1

Category of Veteran	# of Users	Total Estimated Cost (000s)
Core Entitled	2,025,000	$8,760,150
– Service Connected	1,005,000	4,347,630
– NSC Low Inc./Spec.	1,020,000	4,412,520
Eligible/Not entitled	165,000	713,790
TOTAL Veteran Users	2,190,000	$9,473,940

2. For comparison, using 1990 actual average costs by category of care and by veteran category (if available) from Table 1, the following costs were projected:

Table 3 - PROJECTED ANNUAL COST - #2				
Patient Category*	1990	2010	Cost/ Patient	Total Cost (000s)
Inpatients - VA only	1,026,000	770,000	$6,431	$4,951,870
Service-Connected	345,000	259,000	6,442	1,668,478
NSC/Non-vets	681,000	511,000	6,450	3,295,950
Outpatients - VA only	2,556,000	2,173,000	1,031	2,240,363
Service-Connected	992,000	950,000	1,030	978,500
NSC/Non-vets	1,565,000	1,330,000	1,032	1,372,560
Long Term Care - VA	46,000	51,000	17,855	910,605
Service-Connected**	25,000	28,000	17,855	499,940
NSC/Non-vets**	21,000	23,000	17,855	410,665
TOTAL All Categories	3,628,000	2,994,000		$8,102,838
TOTAL Svc-Connected	1,362,000	1,237,000		3,146,918
TOTAL NSC/Non-vets	2,267,000	1,864,000		5,079,175

* Users may repeat in each category of care; total users for all categories exceeds total VA users.
** Data not available on numbers of LTC patients in these categories; estimated based on 55/45% split given that current eligibility is more weighted for SC.

The above projection #2 in Table 3 is predicated on the following assumptions for developing the 2010 breakdown of the number of patients in each care and veteran category.

- 25% decrease in inpatients - based on Commission estimate of decrease in 2010 inpatient bed levels.
- 15% decrease in outpatients - based on Commission estimate of decrease in 2010 outpatient visits.
- 10% increase in LTC patients - no statistical base; assumes significant increase in long term care use because of aging veteran population, and attractiveness of no cost/reduced cost of VA care.
- Ratios of Service Connected to NSC in each category of patient will remain the same as in 1990.
- The 1990 average of 8.0 visits per outpatient user will continue.

It is reasonable to further assume that the costs projected above may be on the low side given that they do not include costs for certain services that presently are not available at all or only under limited circumstances. These would tend to be less expensive services, including preventive health screening tests, dental and optometric services, and home-based services. Although it is difficult to reasonably estimate the usage and total cost to VA of providing these services, it is not unreasonable to presume an additional cost of 2% - 5% of the total projected annual cost would be incurred.

Potential Range of Costs of Additional Services: $162,288,000 (2%) - $405,719,000 (5%)

D. Summary of Estimated Costs of DAV Proposal:

Table 4 - ESTIMATE OF DAV PROPOSAL
(000s)

Veteran Category	Proj. Cost*	Addtl. Costs**	Total Cost
Core Entitled	$7,515,008	$375,751	$7,890,759
– Svc.Connected	3,146,918	157,346	3,304,264
– Low Inc./Spec.#	4,368,090	218,405	4,586,495
General Eligibles##	711,085	35,554	746,639
TOTAL	$8,226,093	$411,305	$8,637,398

* From Cost Projection #2 - Table 3.
** Based on 5% of Proj. Cost.
\# 86% of projected NSC users in all care categories.
14% of projected NSC users in all care categories.

E. Estimated Cost after Reimbursement:

Based on the assumption that 75% of the VA patients are insured (private, Medicare, Medicaid, CHAMPUS, etc.) and that 70% of VA costs would be reimbursable by the third parties, the following estimates were developed for providing care to the categories of veterans described in the DAV Plan.

Table 5 - ESTIMATE AFTER REIMBURSEMENT
(000s)

Cost Category	Amount
Core Entitled (DAV Proposal)	$7,890,759
General Eligibles (non-entitled)	746,639
-- Reimbursement	(391,985)
Net Cost - Gen. Eligibles	354,654
TOTAL	$8,245,413

For purposes of comparison and condition, the following estimate displays costs based on the assumption that reimbursement (based on same conditions as above) would be sought for any veterans other than service-connected veterans.

Table 6 - OPTIONAL ESTIMATE - AFTER REIMBURSEMENT
(000s)

Cost Category	Amount
Core Entitled (Svc.Connected)	$3,304,264
All Other (NSC) Veterans	5,333,134
-- Reimbursement	(2,922,430)
Net Cost - All NSC Veterans	2,799,895
TOTAL	$6,104,159

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
JULY 21, 1993
QUESTIONS SUBMITTED FOR THE RECORD BY
CHAIRMAN LANE EVANS
TO
PAUL EGAN
VIETNAM VETERANS OF AMERICA

1. What criteria should be used to judge VA eligibility reform proposals?

VA eligibility reform should establish clear-cut criteria which allow eligible veterans to receive the full continuum of care, either within the VA system or from a non-VA provider at VA expense through contract or fee-for-service arrangements, to include both inpatient and outpatient care. Anything less than access to the full continuum of care represents inadequate health care by current private sector quality standards, and therefore should be judged unacceptable.

In addition, VA's eligibility reform proposals should be judged based upon how well they will accommodate anticipated patientload once national health reform is implemented. In other words, those veterans who will either continue to or begin to receive care at the VA should have open access to the range of medically necessary treatment at the VA, or at VA expense. There will be countless veterans, however, that will not choose to utilize VA health services once an alternative is available. Therefore framers of VA eligibility reform need to be cognizant of anticipated outflow of patients and make sufficiently liberal eligibility policy decisions to reflect this reality.

2. Please identify the changes in VA eligibility currently recommended by your organization.

If the cost of eligibility changes recommended by your organization has been estimated, please provide the estimated cost.

VVA has not made proposals about which specific groups of veterans should be able to access health care from the VA, nor do we have cost estimates. We would reiterate, though, that our assessment concludes that VA may have a lower patientload once national health reform is implemented, giving all veterans currently dependent on VA an option to access health care through non-VA providers. The exception is those specific groups of veterans likely to choose VA care because the VA possesses superior capabilities to serve these specific health problems, such as veterans with spinal cord injuries, blinded veterans, those being treated for substance abuse and/or Post Traumatic Stress Disorder, aging veterans, etc.

Again, the only specific eligibility reform we would advocate is that any veteran who is eligible to receive health care at the VA should be able to receive the full range of services for service-connected conditions at VA expense, and should be able to receive the full continuum of general care for non-service connected conditions with a patient copayment.

AMVETS'
RESPONSE TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS

VETERAN ACCESS TO VA OUTPATIENT CARE
AND RELATED SERVICES
JULY 21, 1993

1. QUESTION: WHAT CRITERIA SHOULD BE USED TO JUDGE VA ELIGIBILITY REFORM PROPOSALS?

Eligibility reform must:

a. provide eligibility rules that are easily understood;

b. recognize the federal government's continuing obligation to assume responsibility for the treatment of veterans;

c. provide access to a full continuum of quality care;

d. promote shifting resources towards a grassroots system model;

By incorporating flexibility in eligibility rules to allow VA to become provider of only resort when necessary, many veterans who now live in areas that are not and will not be served by the private sector (rural/inner city) will gain increased access to VA care. Without government-sponsored care, these veterans will have extremely limited access to any sort of treatment. Vet Centers, outpatient clinics, storefront clinics and mobile units should receive increased emphasis.

f. provide access to care through some mechanism to all honorably separated veterans.

The system should be a mix of in-house VA treatment, fee-for-service and a participatory VA health insurance program.

2. QUESTION: PLEASE IDENTIFY THE CHANGES IN VA ELIGIBILITY CURRENTLY RECOMMENDED BY YOUR ORGANIZATION. IF THE COST OF ELIGIBILITY CHANGES RECOMMENDED BY YOUR ORGANIZATION HAS BEEN ESTIMATED, PLEASE PROVIDE THE ESTIMATED COST.

AMVETS concurs with the eligibility reform guidelines published in the FY 1994 edition of the Veterans Service Organizations' Independent Budget for the Department of Veterans Affairs. Briefly, AMVETS supports a full continuum of care for service-connected disabled veterans, medically indigent veterans, veterans who are uninsurable, veterans who are catastrophically injured and those special categories like WWI veterans, POWs and those exposed to ionizing radiation or hazardous chemicals. All other veterans should be eligible for low cost VA-sponsored health insurance that would cover treatment in VA or private sector facilities. We have no cost data, but the that data may be available in the next Independent Budget for the Department of Veterans Affairs.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

September 1, 1993

The Honorable Lane Evans
United States House of Representatives
Washington, D.C. 20515

Dear Congressman Evans:

It is my pleasure to respond to your post hearing questions ensuing out of the July 21, 1993 House Veterans Affairs Subcommittee on Oversight and Investigations hearing on veteran's access to VA out-patient care and related issues. I would also take this opportunity to thank and commend you for your extraordinary diligence as a member of the Veterans Affairs Committee and as the Chairman of its Subcommittee on Oversight and Investigations.

1. What Criteria should be used to judge VA eligibility reform proposals?

Our primary criterion is the ability of the plan to meet the unmet need for health care. It should expand access to a full continuum of care to the service-connected, medically indigent, and those with catastrophically costly conditions. Further, any such plan should also expand access to the remaining universe of veterans providing the same full continuum of care with payment. Payment being made by third party payer/insurers, and deductible/co-payments or direct premium payments to VA. The revenue must be kept within VA in order to enhance its capacity to meet increased workload.

2. Please identify the changes in VA eligibility currently recommended by your organization.

The attached resolution #719 and White Paper highlights the VFW's position.

3. If the cost of eligibility changes recommended by your organization has been estimated, please provide the estimated cost.

Estimated cots contained in The Independent Budget for VA are based on current criteria. We do not have an estimate based on our proposed changes. We recognize there will be increased costs during the start up years, but costs will eventually stabilize--and even decrease--as VA is allowed to retain third party revenue coupled with its ability to deliver increasingly cost effective health care.

Sincerely,

Dennis Cullinan, Deputy Director
National Legislative Service

VFW POSITION PAPER

IMPROVED ACCESS TO VA HEALTH CARE

VFW Resolution No. 719 (attached) is entitled "Eligibility Reform for Access to VA Health Care". This resolution highlights the VFW thinking in the matter of reforming the current laws and regulations governing access to VA health care. It establishes a firm position which we can use to negotiate toward our goal of improving such access. As with any resolution, it outlines the problem and offers suggested solutions, and calls upon the appropriate body to provide the relief requested.

Resolution No. 719 consists of the eight clauses leading up to the "BE IT RESOLVED" conclusion. The first three of those introductory clauses address the underlying problems as the VFW sees them. Let's begin with the first of those three:

-- "WHEREAS, the existing laws governing eligibility for access to VA health care are clearly illogical in that some veterans are eligible for certain types of VA medical care and not another; and"

This opening clause summarizes the fundamental inequities of the VA health care delivery system today. It flies in the face of logic that certain of our veterans applying for care to VA are eligible to be treated as an inpatient, yet there are severe restrictions on providing those same veterans with the benefit of outpatient care. How can the credibility of VA as an institution continue when its admission policies are arbitrary to the point of discrimination?

The second of those three introductory clauses which outline the problem is as follows:

-- "WHEREAS, those same rules governing eligibility virtually ensure that VA is unable to provide a full continuum of care to many who approach it, a situation which is contrary to sound medical practice, and"

Now that we have justifiably assailed the rules governing access, we are driving home the point that the capriciousness of those laws jeopardize the health of many veteran patients. If VA is able to evade responsibility for the full range of needed treatment to be provided to a veteran patient, consider the implications. Think of that veteran who recognizes that he is ill, yet refrains from seeking care from VA since he is justifiably confused about his possible entitlement, or lack of it, to outpatient care. When he finally approaches VA, his condition has deteriorate to the point where he requires treatment as an inpatient. Such a circumstance is clearly contrary to sound medical practice as is stated in our second "WHEREAS" clause.

The third of our introductory clauses homes in on the underlying problem which has brought us to the present sorry state of affairs vis-a-vis VA health care. It states as follows:

-- "WHEREAS, the continued failure to adequately fund the VA health care delivery system according to its needs exacerbates the problem by forcing VA to increasingly ration the care it does provide, and"

Increasingly starved for the money it needs to do the job right, VA naturally reacts like any other institute which is hard pressed. First it cuts the fat, and then it continues to cut closer and closer to the bone. Medically desirable services are the first to go, and then substitutions, postponements, and treatment mode selectivity take their toll. That is where VA finds itself today.

The next four clauses of VFW Resolution No. 719 show where we are coming from as an organization. If we are going to nudge the VA and the Congress in the direction of eligibility reform, we have to be a part of the process. Since both VA and the Congress have been slow to act, we are putting our thoughts on the table upfront. While we may not get it all, there should be no doubt in the minds of both the Agency, the Congress, and the Administration about where we feel eligibility reform ought to start.

The first of these four clauses states as follows:

-- "WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement in law to access the full continuum of VA health care; and"

The VFW agrees with the prevailing consensus that some form of national health care is coming. It may be closer than any of us think. For VA to survive in such an environment, we feel that an expanded universe of veterans ought to be able to choose VA as their primary health care provider

As we proceed further in examining the assumptions of Resolution No. 719, we need to pause here to differentiate between two terms. The first of these is "entitlement" which establishes the legal right. However, that "entitlement" must be further confirmed by the establishment of "eligibility". The differentiation in their meaning in Resolution No. 719 should become clear as we go on.

For example, the second clause of these four begins to define the concepts of "entitlement" and "eligibility" more precisely as follows:

-- "WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100 percent, as well as those veterans in receipt of VA pension, and those nonservice-connected veterans whose lower incomes currently qualify them for limited access via "means testing"; and"

There is no room for misinterpretation there. All service-connected veterans, all veterans in receipt of VA pension, and all nonservice-connected veterans already eligible for access to VA because of their lower incomes now should access the full continuum of VA health care. This would bring uniformity and do away once and for all with the present fractured system. VA would benefit by being placed in a position for the first time to be able to quantify the actual need for its services

Next, Resolution No. 719 focuses on the remaining veteran population, those who cannot establish their eligibility to exercise their mandated entitlement to VA health care as do those defined immediately above. That clause reads:

-- "WHEREAS, we believe that the remaining expanded universe of veterans with this mandated entitlement could establish their eligibility by some form of payment option, such as third party insurance, Medicare, out-of-pocket payment, or even by payment of medical insurance premiums directly to VA, and"

Simply stated, Congress should fund the VA medical care provided to those service-connected, on pension, and those with lower qualifying incomes. The other potential sources of reimbursement to VA, from the remaining universe of veterans as noted above, would serve to infuse additional dollars into the system. Additionally, we believe that the access of these additional veterans would serve to reinforce the system by expanding the patient mix, which would serve to keep VA competitive in the various medical specialties

The penultimate clause pins the Congress, the Administration, and VA down by defining clearly what the VFW means by the full continuum of VA health care. That clause is quoted as follows.

-- "WHEREAS, we believe that those veterans who establish their eligibility via one or another of the methods outlined above are entitled to the full continuum of VA care which is defined as ranging from preventive through nursing home care, and which recognizes the VA as "case manager" for the full range of ancillary services as well; and"

There is no "wiggle" room left there. No matter the outcome in terms of redefining eligibility for VA health care, those veterans who are accepted for that care should get it all without qualification

The final narrative clause in Resolution No 719 reminds VA, the Congress, and the Administration that the VFW is not alone in recognizing that something must be done in the matter of eligibility reform. The Commission on the Future Structure of Veterans Health Care, assembled by the former Secretary of Veterans Affairs himself, is in our corner on many of these issues Thus, the final clause spotlights that point as follows

-- "WHEREAS, the Commission on the Future Structure of Veterans Health Care corroborated most of these points, especially the need for eligibility reform and the furnishing of a full continuum of care to veteran patients in its report to the Secretary of Veterans Affairs, now, therefore"

Which leads us to our Resolve The mandate of the Veterans of Foreign Wars of the United States, approved by the delegates to its Convention. Resolution No 719 concludes as follows

-- "BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility for VA health care by using the considerations raised in this Resolution as the basic building blocks to achieve that goal."

Attachment VFW Resolution No 719

11/92

RESOLUTION NO. 719

ELIGIBILITY REFORM FOR ACCESS TO VA HEALTH CARE

WHEREAS, the existing laws governing eligibility for access to VA health care are clearly illogical in that some veterans are eligible for certain types of VA medical care and not another; and

WHEREAS, those same rules governing eligibility virtually ensure that VA is unable to provide a full continuum of care to many who approach it, a situation which is contrary to sound medical practice; and

WHEREAS, the continued failure to adequately fund the VA health care delivery system according to its needs exacerbates the problem by forcing VA to increasingly ration the care it does provide; and

WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement in law to access the full continuum of VA health care; and

WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100%, as well as those veterans in receipt of VA pension, and those nonservice-connected veterans whose lower incomes currently qualify them for limited access via "means testing"; and

WHEREAS, we believe that the remaining expanded universe of veterans with this mandated entitlement could establish their eligibility by some form of payment option, such as third party insurance, Medicare, out-of-pocket payment, or even by payment of medical insurance premiums directly to VA; and

WHEREAS, we believe that those veterans who establish their eligibility via one or another of the methods outlined above are entitled to the full continuum of VA care which is defined as ranging from preventive through nursing home care, and which recognizes the VA as "case manager" for the full range of ancillary services as well; and

WHEREAS, the Commission on the Future Structure of Veterans Health Care corroborated most of these points, especially the need for eligibility reform and the furnishing of a full continuum of care to veteran patients in its report to the Secretary of Veterans Affairs; now, therefore

BE IT RESOLVED, by the 93rd National Convention of the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility for VA health care by using the considerations raised in this Resolution as the basic building blocks to achieve that goal.

Adopted by the 93rd National Convention of the Veterans of Foreign Wars of the United States, held in Indianapolis, Indiana, August 14-21, 1992.

Resolution No 719

Responses To Questions
Submitted by
The Honorable Lane Evans, Chairman
House Veterans' Affairs Subcommittee
On Oversight and Investigations
Regarding July 21, 1993 Hearings
On
Veteran Outpatient Care and Related Issues

1. Question: What criteria should be used to judge VA eligibility reform proposals?

The basic objective of eligibility reform is to correct the current fractured and disjointed system of eligibility that allows certain veterans access to a full range of services while setting up barriers to the full continuum of care for others. The most glaring examples are the restrictions on outpatient care which force VA providers to seek more expensive inpatient alternatives to get around the ambulatory care eligibility roadblocks. Undeniably, otherwise eligible veterans will fall through the cracks of such a system. VA will continue to pay for costly inpatient care where less expensive outpatient services would be equally effective.

Lack of clear eligibility for outpatient services also precludes the regular provision of many preventive care services giving the veteran access to the system only to obviate the need for hospitalization or when a condition has deteriorated to a potential degree of seriousness.

The range of benefits offered under any eligibility reform proposal must be tailored to meet the needs of the veteran population. From this standpoint, the VA benefit package must be compatible with any national health care reform basic package. But, at the same time, the VA plan must include those services that would be required by an aging veteran population as well as those services that have already made VA unique in meeting widespread needs of the veteran population. Such services include care and rehabilitation for spinal cord injured veterans, blind rehabilitation, prosthetics, mental health services and especially long term care, among others. Most of these services would not be available outside the VA in the general national health-care plan. The object of selecting these criteria is to both develop an eligibility package that meets veterans' specific needs as well as to keep VA competitive in being able to attract and maintain a stable patient population.

2. Question: Please identify the changes in VA eligibility currently recommended by your organization. If the cost of eligibility changes recommended by your organization has been estimated, please provide the estimated cost.

As stated in our testimony, PVA has called for eligibility reform that would provide the full continuum of care, inpatient, outpatient, preventive and long term care services for a "core group" of eligible veterans. The "core group" should consist of all current Category A-eligible with the addition of another subgroup consisting of "catastrophically disabled veterans."

PVA has not conducted a complete funding analysis of this proposal. However, it is clear from the analysis we have done using current utilization rates in the VA patient treatment file, that substantial portions of the additional cost of eligibility reform could be covered by:

Shifting treatment modalities from inpatient to more cost-effective outpatient settings.

Improving preventive care services.

Shifting from inpatient nursing home care to more cost effective case managed home-based and community-based services.

Collecting and retaining third party reimbursements from private insurers and other federal health programs for the cost of all nonservice-connected care.

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